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ABSTRACT

This report presents highlights from a conference convened to discuss issues related to the enhancement of the ability of urban maternal and child health (MCH) programs at the local level to improve the health and well-being of children and families. In part 1 of the document, speeches concerning the federal and local perspectives on maternal and child health as well as information introduced to dispel the myths about urban families and children are presented. Speakers include Audrey Hart Nora, Acting Director of the Maternal and Child Health Bureau of the Health Resources and Services Administration; Antonia Coella Novello, United States Assistant Surgeon General; and Paul Nannis, President of the U.S. Conference of Local Health Officers. The second and by far the longer part of the report consists of a series of profiles of successful urban MCH programs submitted by 57 cities throughout the United States. Appendices include the 1993 conference planning committee member and registrant lists, and the conference program. (GLR)

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Strengthening Urban MCH Capacity

Urban Maternal and Child Health 1992 Leadership Conference

Conference Highlights

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"Strengthening Urban MCH Capacity"

Urban Maternal and Child Health
1992 Leadership Conference

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CONFERENCE HIGHLIGHTS

Supported by
Maternal and Child Health Bureau
Health Resources and Services Administration
Public Health Service
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Magda G. Peck, Sc.D., P.A., Editor

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CityMatCH is a national organization of urban maternal and child health programs and leaders. CityMatCH was initiated in 1988 to address the need for increased communication and collaboration among urban and maternal and child health programs for the purpose of improving the planning, delivery, and evaluation of maternal and child health services at the local level. CityMatCH, through its network of urban health department maternal and child health leaders, provides a forum for the exchange of ideas and strategies for addressing the health concerns of urban families and children. CityMatCH also has developed a centralized information base about the current status of maternal and child health programs and leaders in major urban health departments in the United States. For more information about CityMatCH, contact Magda Peck, CityMatCH Executive Director, Department of Pediatrics, University of Nebraska Medical Center, 600 South 42nd Street, Omaha, NE 68198-2170, Telephone (402) 559-8323.

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Table of Contents

Co-Sponsors and Funders v
Acknowledgments vi

I. CityMatCH Plenary Session

Welcome Remarks 1
Betty Thompson, R.N., C.F.N.C.
Co-Chair, 1992 Urban MCH Leadership Conference
Director of Maternal and Child Health Programs
Metropolitan Health Department
Nashville, TN

Federal Perspectives on Urban MCH 3
Audrey Hart Nora, M.D., M.P.H.
Assistant Surgeon General
Acting Director
Maternal and Child Health Bureau
Health Resources and Services Administration

Dispelling the Myths of Urban Families and Children 9
Antonia Coella Novello, M.D.
United States Surgeon General
U.S. Public Health Service

MCH in the Cities: A Local Perspective 15
Paul Nannis, M.S.W.
President, U.S. Conference of Local Health Officers
Commissioner of Health
Milwaukee Health Department

II. Profiles of Successful Urban MCH Programs
Cities Submitting 1992 Profiles 21
Profile Index: Categories of Urban MCH Problems by City of Responding Health Departments 23
1992 Profiles 26

III. Appendices

A. Conference Planning Committee 140
B. 1992 Conference Program 142
C. Registration List 148
D. Order Form 154

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National Association of County Health Officials
National Commission to Prevent Infant Mortality
National Governors' Association
National League of Cities
U.S. Conference of Local Health Officers
U.S. Conference of Mayors

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The only way to make a great conference even better is for a talented team of hardworking individuals to pool their resources and creative drive. That is just what happened again in 1992. CityMatCH is fortunate to have excellent staff in the Department of Pediatrics at the University of Nebraska Medical Center (UNMC) in Omaha. DeAnn Hughes provided able leadership as the Conference Coordinator. She was aided by Joan Rostermundt, CityMatCH Administrative Technician, and Elice Hubbert, the Coordinator of our Cooperative Agreement with the Maternal and Child Health Bureau. Staff Assistant, Barbara Sims, helped shape the Profiles in these highlights. The attractive set of conference materials and highlights were designed by Joe Edwards in UNMC Biomedical Communications and printed under the direction of Mark Watson in UNMC Printing and Duplicating. Diane Ruskamp again assisted in our conference fiscal management.

The extraordinary relationship established in 1991 between CityMatCH staff and the conference staff at the National Center for Education in Maternal and Child Health (NCEMCH) continued with the 1992 Conference. Under the able leadership of Rochelle Mayer, and with the competent attention of Paula Sheahan, Lisa Sloan and Maureen Sellar, again the conference thrived.

A hard working and creative Conference Planning Committee gave shape to the program. Co-Chairperson, Betty Thompson guided us smoothly through the three days in Washington, D.C. Patricia Tompkins and her staff at the D.C. Office of Maternal and Child Health arranged an excellent tour of D.C. area MCH programs.

Lastly, the success of the conference rests in large part on each and every participant. The Urban MCH Leadership Conference is a stellar, productive event because urban MCH leaders commit their time and energy to the frank exchange of information about what works, what doesn't and why. Indeed together we can enhance our work on behalf of urban families and children.

Magda G. Peck, ScD PA
Co-Chairperson
1992 Urban Maternal and Child Health Leadership Conference
Executive Director, CityMatCH

Section
I

CityMatCH Plenary Session

Welcoming Remarks

Betty Thompson, RN, CFNC
Co-Chair, 1992 Urban MCH Leadership Conference
Director of Maternal and Child Health Programs
Metropolitan Health Department
Nashville, TN

Good morning! On behalf of CityMatCH, I would like to welcome those of you who are attending the conference for the first time and greet those of you who are returning to the third CityMatCH Conference. CityMatCH is a free-standing national membership organization of city and county health departments' maternal and child health programs and leaders representing urban communities in the United States. The mission of CityMatCH is to enhance the ability of maternal and child health programs at the local level to improve the health and well-being of children and families.

This is the third conference that I have attended and can honestly say that I have learned a great deal and enjoyed the comraderie more each time. In trying to explain the CityMatCH Conference to others, I often compare it to a reunion of war veterans. United by our mandates to fight the wars of low birthweight, infant mortality, premature labor, and low immunization rates. Too often; however, we get caught up in the war of battling for funds to implement needed programs, battling a lack of communication with the state agency, lack of managerial support, and budget constraints. Our wars differ only by nature of the numbers that we serve and the intensity of the problems. Regardless of the size of the city, we share a commonality that binds all of us together: caring for women and children. We are here today to prepare that defense for the women and children.

Prior to CityMatCH we really had no mechanism for sharing information, plotting strategies, or developing game plans to implement in fighting these wars on the local level. Tomes of MCH materials may be printed but rarely disseminated to such a large group. Information is often presented on the State level and does not filter to the local level where the battle rages. CityMatCH was born in 1989, crawled in 1990, and at our 1992 September Conference (today) we are walking and talking. We have developed bylaws, and elected a Board of our peers to act when this body is not assembled. Additionally, a newsletter has been developed that is superior. Compliments to the CityMatCH staff.

I urge you, during this conference, to communicate with your CityMatCH Regional Representative and other Board members; let them know your needs. Remember, this is your conference and should be designed to meet your needs. Your presence here today says that you are going to broker for your community. Together we are going to begin the development of a unified front in the battles for women and children. When I filled out the survey three years ago, I did not dream that I would be a co-chair of the conference today. Next year, it could be you. I urge you to get involved. We need each person in this room, we need to know what works and what you have tried that does not work. Let's have a wonderful conference.

Thank you.

Urban MCH in the Spotlight: Implications for Federal, State, and Local MCH Relationships

Audrey Hart Nora, MD
Assistant Surgeon General
Acting Director
Maternal and Child Health Bureau
Health Resources and Services Administration

Introduction

Thanks to all of you who have done, and are doing, so much to improve health care for mothers and children by strengthening urban MCH capacity. Today is a first for me -- my first attendance at a CityMatCH conference, but I have been aware of your meetings and your working together to build urban MCH connections and to forge urban MCH partnerships. And I am delighted to participate in a discussion of how, together, we can strengthen the MCH capacity in cities and urban areas.

All of us who represent all levels of government and all child health programs share a concern about how we can fulfill our mandates of assessment, monitoring and surveillance, policy development, and leadership and assurance that health services are available for and accessible to all who need them, especially those who have the greatest needs. This would be an enormous task in the best of times, but these are not the best of times. We know that our cities are tinder boxes of tensions -- ready to explode over all kinds of social issues. We know that an influx of different nationalities to our cities has created special health needs. We know that we must become culturally competent to meet their needs. And we know that resources for all governments and all agencies are low. We know that there is competition for the existing dollars. There are those who feel that putting attention on cities shifts attention from other pressing MCH problems and populations. That the immense needs of the cities can dwarf the needs of suburban and rural women and children.

Yes, we know that the problems are great. But we also know that, working together, we can solve the problems. We can develop systems of care. We can meet the needs of urban MCH programs. And what are those needs?

What Do Urban MCH Programs Need?

- Urban MCH Programs need good leaders with the skills and experience to design, implement and evaluate effective interventions. In concert with state and federal counterparts, urban MCH directors must provide skilled leadership at the local level. Urban MCH program directors must be key contributors to the development of local MCH policy, and must have the expertise to facilitate community-based collaboration. Urban MCH programs must be culturally competent to response to the diverse multi-cultural needs of changing urban

populations. This conference provides one mechanism to strengthen skills and hone leadership capacity.

- Urban MCH programs need timely and reliable data and information to monitor their efforts and build a vision for the future. Community-based needs assessment based upon neighborhood-specific and population data is key to planning and program implementation. Urban MCH directors must be full partners with state MCH counterparts in monitoring progress toward reaching the Year 2000 Objectives and implementing OBRA 89 provisions.
- Urban MCH program directors need to connect their activities with related efforts across the country. They need to know what works, what doesn't, and why so that precious resources can be invested in proven solutions.
- Urban MCH programs need adequate resources to do the job. Combined federal, state and local funding and public-private partnerships should maximize limited resources.
- Urban MCH programs and their leaders need to be better connected to their state and federal MCH colleagues. This is not a time for cities to compete with states for scarce resources, but rather an opportunity to work for greater collaboration and partnership.

What is the Federal Response?

The commitment of the Health Resources and Services Administration to the health and well-being of urban children and their families is demonstrated by its many current initiatives. They include a variety of SPRANS funded special initiatives, the Healthy Tomorrows Partnership for Children Program, the Joint HRSA/CDC Data Conference in Atlanta last January, and Healthy Start (which Dr. Harmon will discuss further and about which Dr. McCann will give you an update tomorrow).

The Maternal and Child Health Bureau also has demonstrated its commitment to MCH in cities by the Cooperative Agreement between MCH and CityMatCH under the Partnership for Information and Communication, and its support for CityMatCH for this urban MCH conference.

In addition, there are two new Federal programs initiated by the Maternal and Child Health Bureau which I would like to highlight today, the Community Integrated System of Services -- or CISS -- and the Los Angeles Mentor Program -- LAMP.

Community Integrated System of Services (CISS)

OBRA 1989 provided for a new set-aside program that would be activated when the Title V annual appropriation exceeded 600 million dollars, as it has for the current fiscal year, 1992. This is the CISS program. It is designed to complement the Healthy Start initiative and the State system building efforts by making available to any public or private entity direct support for services integration through use of one or more of six specified strategies that focus on a way of working toward the realization of comprehensive community-based, public-private systems that can assure family-centered, culturally-competent coordinated care for all children and their

families. The system links the activities of voluntary, private, and public service elements to assure comprehensiveness and continuity of care. The system encompasses prevention and other primary health care and also networks with a variety of other resources including inpatient services, specialized mental health care, education, and child welfare and related social services. The ultimate purpose of service integration at the local level should be reflected in project proposals regardless of strategy or strategies selected.

Six CISS strategies are: 1) home visiting activities; 2) provider participation in publicly funded programs; 3) one-stop shopping service integration projects; 4) not-for-profit hospitals, community based initiatives; 5) maternal and child health (MCH) projects serving rural populations; and 6) less restrictive alternatives (including day care services) to inpatient institutional care for children with special health care needs.

Maternal and Child Health Los Angeles Mentor Program (LAMP)

The Maternal and Child Health Bureau initiated a career development program for high school and college students served by the MCH Adolescent Training Grant at the Charles R. Drew University of Medicine and Science, located in the Watts area of Los Angeles, California. The objective of the program, conducted during the summer of 1992, was to provide students, particularly inner-city youth, with real-life educational experiences that will enhance their understanding of the health of children and families and encourage them to seek careers in maternal and child health.

The first phase of this effort, "MCH Los Angeles Mentors Program" (LAMP), enrolled students in seminars and field experiences that enhanced their understanding of the maternal and child health service system. They observed, and, as appropriate, assisted in the provision of services, and each received a salary and wages. In addition to faculty and staff mentors, undergraduate students served as informal "student" mentors to the high school participants throughout the course of the program. Upon completion of the program, all students submitted a short personal statement on their experience, as well as a 5-10 page paper on a topic related to their assignment. All of them received a certificate of participation, signed by the director of the Maternal and Child Health Bureau. Two students were recognized for the quality of their papers, were invited to Washington, D.C. to attend Child Health Day 1992, and had their essays included in a published compilation of the essays written by the high school and college students enrolled in the program.

What More Can We Do?

In the past, the relationships between Federal, State and Local MCH programs have shifted. Each level of government has taken the lead at some point in history. The introduction of Block Grants in 1982 shifted lead responsibility to the states for MCH and other major public health programs. It was assumed that states could better engage the city and county health departments within their borders in planning and program implementation. OBRA 89 reinforced the need for community-based, comprehensive needs assessment and program planning.

Communication is the key. Within each state there must be open, frank and timely communication between urban and State maternal and child health programs and their leaders.

Federal, State and Local MCH leaders must continue to strengthen their capacity to exchange information and ideas and to coordinate their efforts on behalf of children and their families. And cities must be able to talk with each other about their shared challenges and best changes for successful solutions. CityMatCH has been instrumental in providing effective mechanisms for inter-city communication. The CityMatCH surveys have provided a wealth of previously unknown information about the status of maternal and child health in urban communities. We look forward to learning the results of the 1992 survey, which focuses on immunizations. *CityLights* is an excellent example of how an attractive, substantive newsletter can inform Federal, State and Local policy-makers about urban MCH issues.

We must invest in the infrastructure of maternal and child health in America's cities. We can no longer afford to invest only in State MCH programs without also assuring that there is a viable partner at the local level in major cities and counties to assist in achieving the Year 2000 Objectives and implementing the challenges of OBRA 89. We must be willing to support urban MCH programs with adequate resources to make a difference.

I am told that at the 1990 Urban MCH Leadership Conference, urban MCH leaders in attendance were asked: Did your city or county health department participate in the development of your state's MCH Block Grant application under OBRA 89? Of the 50 cities represented in the audience, only a few hands were raised. Last year when the question was asked again, more hands went up. But when also asked how many urban MCH directors present thought whether their health department has been given enough opportunity to participate in needs assessment and other parts of the Block Grant application, only a few hands remained raised.

Over three years have passed since the enactment of OBRA 89, and the third round of applications have just been reviewed by my office. This morning I ask you again to tell me about your health department's involvement in the preparation of your state's FY 93 MCH Block Grant application: How many urban health departments represented here today were involved in the preparation of this year's MCH Block Grant application for Title V funds? How many of you felt that the level of your health department's involvement was adequate?

Conclusion

The Maternal and Child Health Bureau must help to insure that major cities and counties in the U.S. are invited to play an active role in needs assessment and other efforts related to the development of community-based systems of care and other new aspects of OBRA '89. State MCH programs need to be directed to engage further their counterpart MCH programs in urban health departments as full partners in the planning and delivery of MCH services in cities.

- In Federal Region X, the working relationship between the Seattle-King County Health Department and State Bureau of Parent and Child Services demonstrates an effective partnership for MCH. The Seattle MCH Director has been welcomed as a key player in the development and implementation of strategies to maximize Medicaid expansion. Urban MCH program directors in Region X are now invited to join their State counterparts at regional MCH meetings. We must identify State with less effective relationships

to urban communities and provide incentives and technical assistance to forge these critical partnerships.

The Maternal and Child Health Bureau must support the development of greater expertise and support increased activities in the areas of data and needs assessment in major urban communities. Urban health departments can provide a critical link in the capacity to meet and document achievements toward the Year 2000 Objectives and often have access to information which can complement that maintained by states. Neighborhood-specific analyses of health risks and outcomes, coupled with community-based perinatal and child death reviews may hold the keys to making a greater difference in high risk communities.

- Kansas City (MO), is a full partner with the State MCH programs in needs assessment under OBRA 89, and data revealed through the needs assessment has proven critical state and local level planning and evaluation. We must identify other examples of successful urban-state partnerships in needs assessment and share those tools and successes with other states and cities.

In cities where projects have been funded, Healthy Start embodies tremendous opportunity and potential risk for urban MCH programs. The intent of Healthy Start is to strengthen the infrastructure of public health at the local level to better address the complex web of issues that manifest in high infant death rates. We must be sure that this intent is realized, and that Healthy Start becomes fully integrated with existing MCH programs at the local level. Otherwise, we may run the risk of superimposing an enormous special project on already burdened local health departments whose existing MCH efforts become cast into the shadows.

We must cultivate leadership in MCH at the local level in America's cities. Bureau support for the annual conference is indicative of that commitment, and more can be done.

- Opportunities for MCH training, both through Title V supported MCH training programs and continuing education, should be expanded to prepare and support directors of maternal and child health programs in major city and county health departments. Curricula in MCH training programs in schools of public health must be expanded to address urban MCH issues. Continuing Education Institutes which now target state MCH personnel should be expanded to include urban MCH directors.

We must work with cities to make sure that in increasing access to medical care we do not forget to safeguard access to public health services as well. Local health departments can play a critical role in assuring access to primary and preventive health services for women, infants, children and adolescents.

- We must pay attention to the possible adverse impact of Medicaid managed care on major city and county health departments who

are providers of direct primary care services. These local health departments may get caught in a dilemma of having to sacrifice preventive services to clients who rely on health department clinics for primary care as well.

The Maternal and Child Health Bureau must be willing to encourage and support alternative new state-local fiscal arrangements that enhance local control while sustaining close State involvement. For example, in some states, all MCH Block Grant funds directed at a major urban area are channeled through the local health department in the form of a Mini-Block, with associated shared local-state oversight and monitoring of funding local activities. The local health department is then responsible for facilitating distribution of MCH Block Grant funds, coordinating required OBRA 89 reporting, and coordinating local MCH efforts to avoid duplication and fragmentation of services. In cities like Minneapolis and Philadelphia this seems to have worked well.

- The success of Mini-MCH Blocks from States to cities must be known, from both a local and state perspective, so that recommendations for future policy can be made. Effective models should be studied to identify key elements to success, and to translate these findings to recommendations to states as part of Block Grant implementation.

Lastly, as urban MCH programs emerge as stronger MCH partners, the Maternal and Child Health Bureau must be willing to acknowledge and help ease any tensions which may arise between the State and Local levels.

- Meetings between city, county and state MCH leaders should be encouraged, within larger states and within regions, with Regional MCH staff involvement as appropriate.

Dispelling the Myths of Urban Families and Children

Antonia Novello, MD
Surgeon General
U.S. Public Health Service
U.S. Department of Health and Human Services

Introduction

Good morning. I am honored to be here with you today to participate in the 1992 Urban Maternal and Child Health Leadership Conference. The title of this Conference, "Strengthening Urban MCH Capacity," is, I believe, the direction in which we need to assemble our energies. The needs are great, the challenges are many and the time is short.

Think back, if you will, for a moment to last year, when the hillsides of Oakland, California were ravaged by fire. Downtown Oakland was not badly damaged by the heat of the blazes, but it could have been worse, as they say. As the smoke cleared and that crisis ended, there remained a city chronically plagued by high infant death rates, alarming increases in congenital syphilis, and persistent gaps in prenatal care. Since the riots in Los Angeles, it has become evident that, some of our cities, feel the effects of so many other chronic social ills - poverty, crumbling city infrastructure, and high unemployment. And just a few weeks, and days ago, Florida, Louisiana and now Hawaii suffered the fury of hurricanes, hurricanes that changed course only to skirt the major urban areas and strike savagely at less populated communities. We still are feeling the effects of Andrew -- but what about the poor children of Miami, New Orleans and Hawaii who will have to compete with other children left homeless in obtaining limited funds?

For a few brief days over this past year, all eyes of the Nation have been on our cities. What have we really seen? The magnitude of urban health problems in some areas are great, the tragedy of lost lives compelling, and a broad range of individuals and institutions in this great country are taking notice, and are being part of effective solutions rather than part of the problem. Sad to say, however, many have not. The struggle of urban families and children to live and thrive has not yet made it to many of the hearts and minds of those who can make a difference. That's why we are here today.

Front-line providers, such as the directors of maternal and child health programs in urban health departments, those of you gathered at this Conference today, must reaffirm your commitment and involvement. But you should not be the only ones involved, many more of us need to focus our energies on this issue -- because what is at stake are the children, the elderly, and the entire American family.

The Myths

What has kept us from seeing the harsh realities of urban life and the toll it has placed on families and children who live in our cities? What has kept so many of us from making a

serious commitment to a healthier urban America? I believe that are several myths that has kept us from embracing urban America and I would like to share some of them with you today.

- **It has been said that children in America's cities aren't America's children.** Children born into poverty, children born addicted to crack, children abandoned in the nurseries by mothers too high or too lost to care, children born too small -- too soon, children having children, children killing children. These cannot be our children, can they?
- **It has been said that America's cities are failing, that nothing works anymore.** Some of America's cities, once great, are crumbling. Roads with unfixed potholes and bridges under constant repair create traffic havoc. Insufficient, substandard, unaffordable housing are the flip side to homelessness. Fear for personal safety drive residents indoors or to the suburbs. Public health programs are overburdened and in some places their work goes unrecognized and unnoticed. In spite of their presence and the dedication of public health and health care workers, some urban children are dying from measles, multi-drug resistant TB, lead poisoning and the feeling of despair.
- **It has been said that the Federal government doesn't care about the cities anymore.** A Nation will be lost if we continue to believe that the Federal government has turned its back on the children and families in this nation.

What we should be saying instead is that our destiny and that of our children does not depend on the government alone. Whether we are apolitical, partisan, or activist ours is the best form of government and it is a powerful one. What we need to do is talk less of what the government does not do and learn more how to use it accordingly. The involvement of the private, public and government sectors as a combining force should be the way of the future and budget crises alone should not be the only force that gets blamed for cutting back our basic primary and preventive services.

I am here to say to you today that perceptions versus realities should not drive this country any more. If we are to thrive as a Nation, we must not succumb to misconceptions. A generation is at risk, and it will be lost if we continue to talk only about what we do not have. We must bring urban children out of the shadows of the enormous odds against them, and embrace them as our own. If we do not do this and embrace this window of opportunity, the ongoing myth of failing cities will become a self-fulfilling prophesy, and will not allow us to highlight and learn from the successes that about around us, particularly as we talk about maternal and child health and incorporate them into solutions.

Who Are the Families of Urban America?

I'll tell you, if we are to embrace them, we must know who they are, given them back their faces, their hearts, their souls. We must know where they came from, and support them for what they are, not what what we want them to be. But most importantly we must stop the stereotyping. The portrait of families and children who reside in urban communities in the United States is undergoing significant transition. The urban family is increasingly younger,

poorer, minority and most times headed by a single parent. This trend is apparent not only in the largest American cities, but also in smaller and mid-sized urban communities as well.

- In the past decade, the median income of families with children fell by approximately 5 percent and the income of the poorest families declined by almost 13 percent. At the same time, the costs of health care, transportation, and housing all increased. Of the 19 million children who reside in American cities today, nearly one-third are poor.
- Recent Census data indicate that the number of Hispanic children living in poverty in the U.S. increased by nearly a third during the past decade. An influx of immigrants from Asia, Latin America, and other countries are changing the face of many American cities where the proportion of minorities had been traditionally small.
- As it has been said, more and more children are being raised in single parent families. Almost 13 million children, or one in five, lives in a single-parent family, a rate that has doubled from twenty years ago.
- In 1989 three out of ten babies, or over 1 million, were born to single mothers, almost a third of these mothers were teenagers. Out of every 100 poor children in American, 54 of them live in female-headed households. And it is known that female-headed families suffer extraordinarily high poverty rates.

America's cities are also in transition. In the past decade, many larger cities experienced a net loss in population as those with economic means moved to suburban communities, and those with less stayed in the urban settings. Many cities have experienced an erosion in the municipal health and human services infrastructure, in part due to an eroding tax base and in part due to decreasing available revenues and programmatic support.

Urban families and children also are known to suffer a disproportionate burden of health risks and adverse health outcomes.

- While nearly 30% of U.S. births are to city residents, over 35% of infant deaths are urban. Overall infant mortality in large cities exceeds the U.S. rates by 30%. Black infants born in cities are twice as likely as white babies to die in the first year of life.
- In some inner city neighborhoods, the magnitude of racial disparities in the rates of infant mortality and low birthweight approaches a six-fold difference.
- In many urban communities, lead poisoning, pediatric AIDS, intentional injuries from interpersonal violence, and neonatal drug exposure are endemic.

Urban families and children are known to experience significant barriers in accessing primary and preventive care, some of which are financial, and some of them logistic.

- While Medicaid expansion has increased coverage for some near poor families, in working urban families we still find uninsurance as a common factor.

- The lack of adequate transportation hampers pregnant women from obtaining optimal prenatal care. Public sector facilities often are overloaded; waits of up to three weeks for the first prenatal care appointment are average in many urban communities and the hours the clinics are open are better for the providers than for the clients. Not to mention that, private providers of health care services have become a scarce commodity in many inner city neighborhoods, and minority providers are equally scarce.

If we want to help our cities and our children then we must make these problems our problems. We must also devise programs that are utilizable for the people intended rather than for the bureaucrat that administers it. They must also be devised with women's needs in mind. The care of the future will be successful only when it is found under one roof, it is family centered and community based. The system is there for the people to utilize, but we must be the bridge that brings the system closer to the people.

Urban Maternal and Child Health Programs Which Work

Each of you know, as I do, that there is much good in our daily work. It is hard work, but there are rewards that come from making a difference. And there are many examples of effective urban MCH programs that defy the myth that nothing works in the cities. For example:

- When the yellow MOMobile funded by the Philadelphia Department of Health rounds a corner in North Philadelphia and makes it possible for a young pregnant woman to get the prenatal care she needs, we are seeing cities working to make a difference.
- When San Antonio's children escaped the brunt of the measles epidemic in 1990 because the metropolitan health department pulled together a comprehensive outreach, vaccination and public information campaign, we are seeing cities working to make a difference.
- When the black infant mortality rate falls in Indianapolis from 23.9 to 18.9 after a concentrated health department and community-wide effort to increase access to care, we are seeing cities working to make a difference.
- When the Intercity Minority Church program joins forces with the Metropolitan Housing Outreach program in Columbus, Ohio, to reach out to pregnant women in their congregations and their homes to stress the importance of prenatal care, we are seeing cities working to make a difference.
- When one-stop shopping for prenatal care, WIC, Medicaid, Transportation, social services, child care and family planning are pooled successfully for residents of Zip Code 84111 in Salt Lake City, we are seeing cities working to make a difference.
- When pregnant teens in Jackson, Mississippi can get prenatal care in church-based clinics after church on Sundays, and pregnant high school students can get prenatal care on site in school, and these teens have babies that are healthier and of normal birth weight, we are seeing cities working to make a difference.

- When providers, policymakers, parents and others in the community collaborate in infant death reviews to better understand how better to prevent infants from dying before blowing out that first candle in a birthday cake, we are seeing cities working to make a difference.

Urban MCH Programs like many that I have just discussed with you and I am sure many more represented here today have learned that by mixing the traditional with the untraditional, by finding ways to make services more community-based, culturally sensitive, comprehensive and even cost-effective, public health programs in major cities and counties of this country can and do work.

Does the Federal Government Care About Urban Children and Families?

We know that the Department of Health and Human Services remains committed to the health and well-being of urban children and their families. This commitment is evident in the many initiatives currently targeting or involving major American cities, including Healthy Start, increased funding for WIC and Head Start, Healthy Tomorrows Partnership for children, the new CISS set-aside, a variety of SPRANS-funded special initiatives, the CDC immunization initiative, increased funding for community health centers, the Cooperative Agreement between the Maternal and Child Health Bureau/HRSA and City**MatCH** under the Partnership for Information and Communication, and the support for City**MatCH** for urban MCH conferences.

Conclusion

It is essential that we work together to focus all of our energies to protect our Nation's children, but it is as important that we dismiss perceptions when the reality speaks for itself. Whether your focus is solely on getting our children immunized, or working with children suffering from HIV/AIDS, or supporting campaigns to turn around the epidemic of childhood injuries, and so many others, our combined efforts must not let up -- we cannot afford to hesitate for even one moment because there is no more time to rehearse. A complete generation is at risk.

I know that any of you here would jump from your seat and take off in a dead run to grab a child from the path of a car, you would shield a child about to be hurt, you would endanger yourself to protect a child from a dangerous fall. Well, I know that we are at that point regarding children in our cities. We need a dead run, we need total intuitive conviction. We need to reach these children and protect them from harm. The time has come for action.

I know I am being blunt, but I want everyone to remember that I vowed to speak for all of the children when I was appointed, I vowed to be the Surgeon General for all Americans and I vowed that I will not be silent regarding children and their well-being. One in five American children lives in poverty -- I speak for them. Thirty-eight percent of Hispanic children live below the poverty line; and 43 percent of all African-American children live in poverty -- I speak for them, too.

For whatever work we do with children, we must see with their eyes, hear with their ears, and feel with their hearts. Only when we do this can we truly be empathetic, only then can we really serve children's needs the best.

In the words of the Chilean poet, Gabriela Mistral:

> *Many of the things we need can wait; the child can not. Right now is the time his bones are being formed, his blood being made and his senses are being developed. To him we cannot answer "Tomorrow;" His name is "Today."*

I want you to know that I support you, I admire you, and I pray that the obstacles and frustrations that you encounter will not defeat you, but that you will always have the strength to carry on in your mission, and know that you have made a difference in peoples lives.

God Bless You All.

Managed Care and MCH in Cities: A Local Perspective

Paul Nannis, MSW
President, US Conference of Local Health Officers
Commissioner of Health, Milwaukee Health Department

Introduction

In spite of our best efforts, you and I know that the situation for women and children in urban America is generally not good. While we are grateful for the increase in some categorical funding, such as was just discussed by Drs. Harmon, Nora and Novello, we nonetheless recognize and confront the reality of the situation every day. Whether we are talking about infant mortality, birth weight, immunization levels, childhood lead poisoning, teen pregnancy, or early entry into prenatal care--particularly among nonwhites, especially among the poor--we all know that **WE** continue to have serious problems.

Meanwhile, health care costs have risen far beyond other costs. State and local units of government have been trying all kinds of ways to get control. In Wisconsin, a managed care system was implemented for our Medicaid population in parts of the state, including Milwaukee. I believe in managed care. I believe it **can** work. Since many of you will be moving to this approach in the near future, I would like to speak today about what managed care can and cannot do, and suggest ways I believe it can work better for all involved. My intent is not to cast blame for past problems, but to enable others to learn from them.

What is Managed Care?

Managed care is a system that enrolls patients on a formal membership basis in health care delivery arrangements, acts as a gatekeeper and deterrent to unnecessary and inappropriate care, and usually pays for services on a partial or full-risk capitation basis. In 1984, nearly all the women and children in Milwaukee County who received AFDC were enrolled in managed care. Over a six months period, 110,000 people made this shift in service delivery systems. As we will see, there is a difference between **managed** care and **managing** care.

There are many types of managed care arrangements. In Milwaukee we offer it through health maintenance organizations (HMOs). These come in two basic types--the staff model and the group model.

In the staff model, the physicians and others work directly for the HMO and operate out of HMO-run clinics. In the group model, the HMO contracts with physicians or Physician Associations on a capitated basis. The physicians in the Association usually see patients on a fee for services basis, paid by the Association. They generally maintain their own offices throughout the city.

Such managed care arrangements can work well or badly. I would like to discuss with you our experience in Milwaukee. While I may at times appear critical of the initiative, my intent is to help others learn from our mistakes so that they aren't repeated unnecessarily.

Goals of the Program

Behind our shift of Medicaid patients to managed care were several factors which should sound familiar to you, including health care costs rising above the rate of inflation, the belief that, without controls, costs would continue to spiral out of hand, and the likelihood that, because HMOs were new and competitive in the area, they would willingly compete for Medicaid patients. Wisconsin has a rich Medicaid program offering most of the optional benefits. Therefore, it's an expensive program to run. Meanwhile, our poverty rate was relatively low, so we have to pay a higher share of our Medicaid costs that poorer states, making the state tab even higher.

Where Are We Now and What Have We Learned?

Currently approximately 115,000 persons in Milwaukee are covered through managed care in one of six participating HMOs. Only about 3,000 "high need" women and children remain in fee for service ("straight Title XIX"), and all exemptions from managed care are re-examined periodically.

It is my belief that we were ill-prepared to successfully implement the HMO program in 1984. The emphasis, unfortunately, was on cost containment at the expense of access to care. The HMO's left much up to the public sector to do, despite their contractual obligations, and there was little or no dialogue between the public and private sectors. The ongoing structural problems in the health care delivery system were not addressed, let alone resolved, by the Initiative. The 1989-1990 national measles epidemic hit Milwaukee, too, just as badly as other cities without managed care. This brought our problems to the fore, forcing us to confront them.

Measles Outbreak

Milwaukee had a large measles outbreak from September, 1989 until Spring, 1990. Data gathered during it was analyzed by the Centers for Disease Control as well as by our staff. What we found out was very interesting: Most of the cases were among disadvantaged preschool age children. This gave us an insight into how the HMO initiative was actually working in Milwaukee.

Despite a high rate of HMO coverage, not only was this a serious outbreak, but the outbreak was notable for its severity. Overall there were 1,095 cases, of which 21% (233) required hospitalization; 82% of the cases were among African Americans, although they were only 30% of the population; and 3 inner city toddlers died of this fully preventable disease. All were enrolled in HMOs.

The severity of Milwaukee's outbreak was comparable to that in other cities. The implication, then, is that managed care made little or no difference in immunization coverage and associated preventive health care, much to the disappointment of many.

Clearly the seriousness of the cases was not only because of a lack of immunizations and system failure. It is also true that the overall health status of these children was not good to

begin with due to poverty and related conditions. We believe this because a similar-sized epidemic in 1980 resulted in a hospitalization rate of only 1% and no deaths.

The Milwaukee Health Department surveyed the families of children ages 1 to 4 who came down with measles. We found that 85% of them were on public assistance and 83% were in HMOs. Of those in HMOs, 67% were not vaccinated, and 30% still used the emergency room for their primary care.

Clearly there were some barriers to accessing the care to which they were entitled, and clearly the HMOs--who were capitated to provide managed care--were not managing the care of their patients.

Physician Perspective

The Health Department also followed up with the local physicians regarding their perspective on what happened and their reasons for not vaccinating.

First, physicians receive inadequate and delayed reimbursements, causing them serious financial problems. While the HMOs are paid up-front, the physicians are not. Second, non-economic disincentives to vaccination, such as the new vaccine liability form, caused physicians to fall back on their historical referral of patients to the Health Department for free immunizations. Third, at that time, costly vaccines had to be paid for up-front by the physician, a difficult burden for many inner city providers. And last, practices with large numbers of sick children did not believe they had the time and resources to do preventive care.

Shortage of Providers

The distribution of primary care physicians in the metropolitan area is probably the most critical flaw in the HMO system. The HMOs were at first unwilling, and now seem unable, to resolve this key structural problem. Medicaid practices are not the easiest and most desirable types of practices, given the multiple complex needs of many of the patients. The economics of central city practices are not good.

Like many other cities, Milwaukee had a huge erosion of primary care providers and clinics in the 1980's. Although the Health Department and a few others have taken steps to reverse this outflow of health care resources, both geographical and cultural accessibility in the HMO system continues to be a significant problem.

Lessons of the Epidemic

Failing to provide immunizations costs much more money in the long run. Only one of the six HMOs--the only staff model HMO--expended significant extra dollars during the epidemic to raise immunization levels. Had all of them joined the Health Department in doing so when first alerted to the outbreak, huge hospitalization and other costs could have been avoided. More importantly, we would not have had a fatality rate closer to the Third World than what should be expected in the U.S.

What did the outbreak cost? We estimate costs in excess of $2.3 million in hospital costs alone (233 hospitalizations at $9,936 each). During the outbreak the Health Department

immunized free of charge over 20,000 patients, including 11,000 HMO clients. We saved the HMOs a minimum of $300,000 in preventive health care (11,000 at $28 each), not even accounting for staff time.

Failing to manage the care of the patients resulted in great cost, as well as unnecessary human suffering the death. This is "penny wise and pound foolish," an all-too-common problem in our current system.

So what went wrong? Clearly there is a huge gap in the disease prevention/health maintenance philosophy of the HMOs and actual local practice. In Wisconsin cost containment was perhaps inadvertently emphasized over addressing the needs of the Medicaid population. Secondly, simply no one assumed responsibility for the immunizations. The HMOs were being paid for them, yet physicians failed to give them. They referred patients to the Health Department, but did not follow up to see that they actually came.

Medicaid HMO Task Force

After the epidemic, because there were so many concerns about the quality of the care being delivered and the systemic problems which had become evident, the State of Wisconsin eventually convened a Task Force to examine some of these issues. The Health Department, various advocacy groups, community organizations and physicians sat on this Task Force.

Some of its recommendations, which I suggest be adopted ahead of time in other communities implementing managed care, include:

- Information Centers--The HMOs should set up a community based and geographically accessible centers, staffed appropriately to assist clients with accessing health care.
- Enhanced Reimbursement--The State should encourage HMOs to contract with high quality community health centers. The clinic model works well for addressing the multiple needs of low income families. The system should also increase reimbursement rates to inner city providers who have a disproportionate share of Medicaid recipients, similar to what has been done with "FQHC--Federally Qualified Health Centers." Technical assistance should be provided to smaller, community-based providers to enable them to compete for HMO contracts.
- HMO Advisory Council--Community representatives should sit on an Advisory Council which meets regularly to impact on HMO policy.
- Ongoing Program Evaluation--A State monitoring system should be in place to examine the capitation rate, to make sure it is sufficient, given the nature of the patients served; and whether all participants have equal access and service. Also, the HMO Advisory Council should review the content of the HMO reports on location, ethnic composition of MA certified providers, UR data, QA, grievance procedures, provider education and mental health, and long-term cost effectiveness of HMOs on overall human service systems.
- Scope of Covered Services--Translation services and multidisciplinary services for high risk pregnancies should be covered.

- Community Involvement--The HMOs should be more active in community initiatives which impact on HMO/AFDC families.
- Fee for Service--Families with developmentally delayed children are at risk for underservice and should be covered on a fee for service basis.
- Child and Domestic Abuse Program--The State should set up a pilot to provide immediate access and long term treatment for both perpetrators and victims of abuse and neglect and evaluate this program on an ongoing basis. Instead of sending their patients to physicians, the HMOs should contract with domestic abuse programs for these services.
- Milwaukee County Dept. of Health and Human Services--The State should take steps to improve County performance in adding newborns to AFDC mothers' cases and assisting with transportation needs.

Role of the Health Department

I see the role of the Health Department, given the situation I have described, as one of advocate, to make the system work better. We are doing this in three ways:

Empowerment -- Our staff teach families how to access the health care they are entitled to. I believe we do a disservice if we promote dependency on us when people have an option which offers a full range of medical care. Public health resources should be targeted to those without any coverage at all.

Costs -- During the outbreak, the Health Department did not bill for services. Our emphasis was on immunizing as many as possible, as quickly as possible. Additionally, we did not have the necessary contracts in place to do billing. Since then, we have implemented a billing system so that when we serve HMO patients, we bill the HMO (not the physician) for the service. This has served as a financial incentive for them to reach out to the patients they are capitated to serve. It is also much fairer to the taxpayer who is already paying the HMO for the service. They should not have to pay the city also to do this work. More importantly, we do believe that ideally people should be in systems of care, so that when they have designated providers, care can be delivered by them.

Leadership -- We have been and will continue to work for further improvement in the managed care system so that it lives up to the ideals of truly providing preventive, case management and access.

Response of the HMOs

Like an urban riot, the epidemic called attention to long-standing problems. To a large extent the HMOs have responded. Some are taking a higher profile role in the community on such issues as infant mortality and immunizations. They are participating on collaborative projects related to family health. One HMO is leading a major county-wide initiative to promote prenatal care and appropriate nurturing of young children.

The staff model HMO has been the most responsive of all. I believe its clinic focus and simple structure makes the critical difference in its ability to be responsive and reach its patients. However, as mentioned earlier, we only have one such entity serving our Medicaid patients.

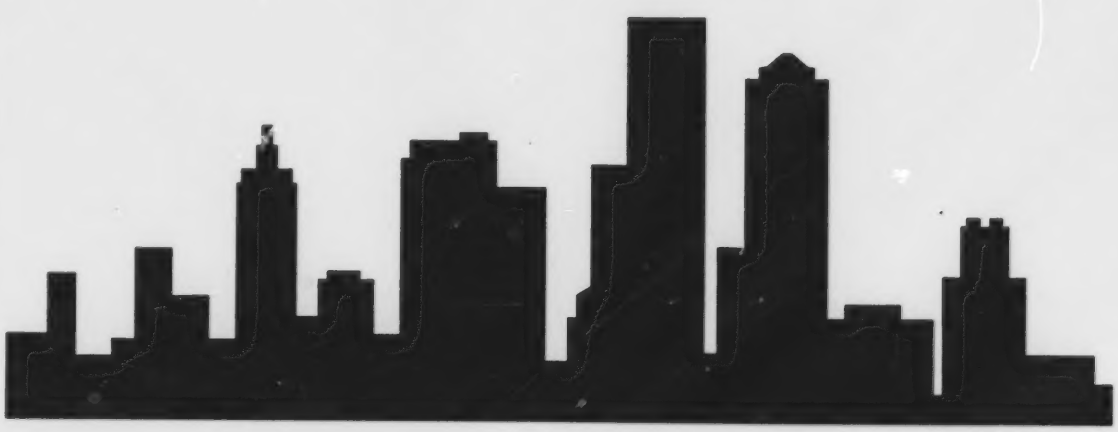
Conclusion

I hope this presentation on Milwaukee's experience has been helpful to you. Again, my intent is not to be critical, but to help others avoid repeating the mistakes which occur when such a complex changeover first takes place. In Wisconsin, we have corrected many of our deficiencies and continue to work on those remaining. The lack of capacity for service delivery in the central city continues to a complex and difficult problem to resolve.

I wish you luck as you embark on similar enterprises. As a final note, I just want to emphasize the need to keep in mind that we are serving women and children, while trying to reduce costs. If in the end, services aren't improved and preventive health care isn't delivered, nothing worthwhile has been accomplished.

Section II

Profiles of Successful Urban MCH Programs



CITIES SUBMITTING 1992 PROFILES:

City	Page	City	Page
Akron, OH	26	Lexington, KY	84
Albuquerque, NM	28	Little Rock, AR	86
Anaheim/Santa Ana, CA	30	Memphis, TN	88
Anchorage, AK	32	Miami, FL	90
Austin, TX	34	Milwaukee, WI	92
Baltimore, MD	36	Minneapolis, MN	94
Baton Rouge, LA	38	Mobile, AL	96
Birmingham, AL	40	New Orleans, LA	98
Boise, ID	42	Newark, NJ	100
Boston, MA	44	New York, NY	102
Charlotte, NC	46	Norfolk, VA	104
Chicago, IL	48	Oakland, CA	106
Cincinnati, OH	50	Omaha, NE	108
Cleveland, OH	52	Philadelphia, PA	110
Colorado Springs, CO	54	Phoenix, AZ	112
Columbus, OH	56	Pittsburgh, PA	114
Corpus Christi, TX	58	Portland, ME	116
Dallas, TX	60	Portland, OR	118
Dayton, OH	62	Richmond, VA	120
Denver, CO	64	Rochester, NY	122
Detroit, MI	66	Salt Lake City, UT	124
El Paso, TX	68	San Antonio, TX	126
Fort Worth, TX	70	San Juan, PR	128
Grand Rapids, MI	72	Seattle, WA	130
Hartford, CT	74	St. Paul, MN	132
Indianapolis, IN	76	Washington, DC	134
Jackson, MS	78	Wilmington, DE	136
Jacksonville, FL	80	Yonkers, NY	138
Kansas City, MO	82		

PROFILE INDEX:
Categories of Urban MCH Problems by City of Responding Health Departments

Immunization	Perinatal Substance Abuse	Early Childhood Development	Manual Record Systems	Smoking Cessation in Pregnancy	Child Abuse
Akron, OH Anaheim, CA Baltimore, MD Detroit, MI Ft. Worth, TX Newark, NJ Phoenix, AZ Pittsburgh, PA St. Paul, MN	Albuquerque, NM Anchorage, AK San Juan, PR	Albuquerque, NM Jackson, MS Pittsburgh, PA Richmond, VA San Juan, PR Yonkers, NY	Anaheim, CA El Paso, TX	Anchorage, AK	Austin, TX Omaha, NE San Juan, PR

Lead Toxicity	Asthma	Foster Care Children	Domestic Violence	Media/PR/ Publications	Substance Abuse
Indianapolis, IN Memphis, TN Miami, FL Milwaukee, WI Portland, ME	New York, NY	Rochester, NY	Charlotte, NC Omaha, NE San Juan, PR Yonkers, NY	Kansas City, MO Minneapolis, MN Philadelphia, PA Washington, DC	Albuquerque, NM Charlotte, NC San Juan, PR

Low Birth Weight	Breast-Feeding	Prenatal Care	Family Health/ Community Services	Infant Mortality	Access to Health Care
Baton Rouge, LA Boston, MA Dallas, TX Hartford, CT Philadelphia, PA Yonkers, NY	Birmingham, AL Pittsburgh, PA	Boise, ID Colorado Springs, CO Grand Rapids, MI Jackson, MS Lexington, KY Portland, OR	Boston, MA Charlotte,NC Chicago, IL Norfolk, VA Omaha, NE Pittsburgh, PA Richmond, VA Washington,DC Wilmington, DE Yonkers, NY	Cincinnati, OH Cleveland, OH Columbus, OH Corpus Christi, TX Dallas, TX Grand Rapids, MI Hartford, CT Jacksonville, FL Little Rock, AR Mobile, AL New Orleans, LA Oakland, CA Pittsburgh, PA Salt Lake City, UT Washington, DC Yonkers, NY	Chicago, IL Dayton, OH Denver, CO Hartford, CT Jackson, MS Jacksonville, FL Lexington, KY Little Rock, AR Minneapolis, MN Mobile, AL New Orleans, LA Newark, NJ Omaha, NE Portland, OR Richmond, VA Salt Lake City, UT Seattle, WA St. Paul, MN Washington, DC Wilmington, DE Yonkers, NY

Sexually Transmitted Diseases	Transportation	Poverty	Parenting	Education/School Drop-outs/ Delinquency	Mental Health
Oakland, CA San Juan, PR	Jackson, MS Jacksonville, FL	Jacksonville, FL Norfolk, VA	Boston, MA Omaha, NE Pittsburgh, PA San Juan, PR Yonkers, NY	Charlotte, NC Norfolk, VA Pittsburgh, PA	Charlotte, NC Norfolk, VA Yonkers, NY

Adolescent Pregnancy	Cervical Dysplasia	Case Management/ Medicaid Billing	Nutrition	Language/ Cultural Diversity	
Baton Rouge, LA Charlotte, NC Dayton, OH San Juan, PR Washington, DC Yonkers, NY	San Antonio, TX	El Paso, TX	Philadelphia, PA	St. Paul, MN Washington, DC	

1992 Urban Maternal and Child Health Leadership Conference

Health Department: Akron Health Department
Contact Person: Lucile Maher
Beverly Parkman
Christine Johnson

City/State: Akron, OH
Telephone: (216) 375-2430

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Immunization compliance by age 2 years improve through a coordinated, community-wide effort.

2. **Describe the *major accomplishments* of this initiative.**

   - Program is in the Planning/Fund seeking/Data Collection phase.
   - Collaborative efforts with Junior League, Children's Hospital Medical center, and the 3 Health Departments in Summit County.
   - Focus on immunization awareness, both public, and professional due to compliance concerns, missed immunization opportunities and recent addition and changes to immunization programs. Logistics: multiple providers in community and not all children have a sole provider.
   - Tracking and follow-up methods being explored.
   - As of July 1, 1992, $48,500 has been raised through foundations; a final Foundation has promised additional monies as 25% match to that raised. The Program was not accepted for Robert Wood Johnson monies.

3. **How is it funded?** Grant Proposals to Akron Community Foundation: Robert Wood Johnson, GAR Foundation, GenCorp Foundation, Knight Foundation (Knight Ridder: owner of the city's daily newspaper). In kind by involved Agencies and Junior League.

   What is the approximate total annual budget for this initiative? $100,511.00 for 3 years.

4. What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?

Barrier 1: Incomplete immunization information for children receiving immunizations at more than one site and not maintaining an Immunization Record.	**How overcome?** Developed agreement among the 4 major local immunization providers to access each others records via computer to avoid missed opportunities when child presents at any of the 4 providers.
Barrier 2: Availability and accessibility by too few evening and/or weekend hours for immunizations.	**How overcome?** Will hold regular evening and/or Saturday clinic at least once a week at one or more sites.
Barrier 3: Methodology and funds to develop broad tracking system.	**How overcome?** Discussions continue to develop best method of tracking system. Computer staff is available to map out program without major expenses; difficulty lies in high level of mobility of client population.

5. How do you know this maternal and child health initiative has been *successful*?

We will compare levels of immunizations prior to initiative with those after the initiative has been in place for the initial 3 years. The enhancement of cooperation among Agencies has opened doors for other ventures.

6. Do you think that this *initiative* would work if implemented in *another urban community*? May easily be implemented anywhere. Most locations have computer capability already. **Why?** Key to success is the cooperation between the individual providers concerned.

1992 Urban Maternal and Child Health Leadership Conference

Health Department: New Mexico Dept of Health City/State: Albuquerque, NM
Contact Person: Bruce G Trigg MD Telephone: (505) 841-4100

1. What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)

Perinatal substance abuse and early childhood development.

2. Describe the *major accomplishments* of this initiative.

The "Milagro Program" is a perinatal substance abuse prevention and treatment program funded through the Office of Substance Abuse Prevention (OSAP). Major accomplishments include:

A. A sophisticated linkage of primary care and substance abuse treatment in the provision of both obstetrical and pediatric care.

B. A reduction in the number of premature births and low birth weight babies in the women treated at Milagro.

C. Intensive intervention for the early identification and treatment of infants and children with developmental problems.

D. The cooperation and coordination of diverse agencies in providing comprehensive prenatal, pediatric, home visiting, drug treatment, and therapeutic family services to substance abusing women and their children.

3. How is it funded? Other Federal Funds

What is the approximate total annual budget for this initiative? $218,000.00

4. What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?

Barrier 1: Childcare for patients. It was difficult for women to attend substance abuse groups or show up for prenatal clinic due to lack of adequate and/or affordable childcare.	**How overcome?** Seeking help from all local volunteer agencies for adults willing to provide on-site childcare at our clinics. Sought donations from local merchants for toys, art supplies, books, etc.

Barrier 2: Philosophical differences among members of a multi-disciplinary team.	**How overcome?** Weekly case management meetings and monthly agency coordination meetings. Face to face contact between pediatricians, psychiatrists, obstetricians, social workers, counselors, nurses, etc. Mature, frank, direct communication.
Barrier 3: Women feared that their babies would be taken away from them because of their drug use resulting in a high no-show rate.	**How overcome?** Establishment of well defined guidelines to share with women when they are admitted to the program. Clearly define what behaviors will lead to a referral to child protective service agency. Establish a contract with patient that actively involves them in the development of the treatment plan. The more involved the patient, the better participation.

5. How do you know this maternal and child health initiative has been *successful*?

The Milagro Program has coordinated the services provided to substance using pregnant and postpartum women. It has provided early, intensive prenatal care, drug treatment services, home visitation, social services, delivery and nursery care, pediatric primary care, and early development assessments and interventions. Both the birth outcomes and developmental outcomes have generally been good.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** This is an excellent model for coordinating already existing services thereby reducing the start-up costs and maintenance of such a program. Before beginning, contact OSAP for information regarding Comprehensive Perinatal Substance Abuse Prevention and Treatment projects they have funded. Learn from the experiences of these ongoing projects.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	Orange County Health Care Agency/Public Health	City/State:	Anaheim/ Santa Ana, CA
Contact Person:	Len Foster Deputy Director of Public Health	Telephone:	(714) 834-3882

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Inefficient, costly and unproductive manual immunization record system encompassing more than 350,000 records.

2. **Describe the *major accomplishments* of this initiative.**

   The County has established a computerized, multi-site and multi-user, immunization data system for its Public Health clinics which:
   - meets all current CDC and State reporting requirements;
   - reduces paper records by 98%;
   - provides for remote access of individual patient immunization status;
   - provides capacity for on-line documentation of immunizations administered;
   - permits automatic printing of reminder/recall notices for patients;
   - allows for the safeguarding of patient data and its transfer to larger computer platforms;
   - guarantees adequate controls for confidentiality;
   - permits the downloading of other data, including birth certificate information and data from other providers, into the system; and
   - provides the opportunity for the County to utilize the immunization software as the foundation for the creation of a County-wide, comprehensive computerized data system through which to link all providers of immunization services.

3. **How is it funded?** City/County/Local government funds.

   What is the approximate total annual budget for this initiative? $50,000

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**	
Barrier 1: A five year nationwide search failed to identify an existing successfully operating immunization data system which met the needs of Orange County.	**How overcome?** The County designed and wrote its own immunization data system.
Barrier 2: No new funds were available to develop the immunization data system.	**How overcome?** The initial consideration of purchase of The Immunization Standard software system was rejected due to cost. A WANG VS 65 computer was acquired from another governmental agency at no cost. The County hired a former WANG programmer who was capable of writing a COBOL language program for Orange County.
Barrier 3: Overcoming resistance within the County to the allocation of precious programming resources to a project which is not offset by outside revenues.	**How overcome?** The management staff of Public Health was successful in convincing County policy makers that in the face of recent measles outbreaks, and the essential nature of maintaining adequate immunization levels required immediate implementation.

5. **How do you know this maternal and child health initiative has been *successful*?**

The success of this initiative cannot yet be judged. Actual implementation was initiated in July of 1992. It will require at least six months to determine if the principal operating components operate as designed. However, we have every confidence that the resulting evaluation will be consistent with our anticipation.

6. **Do you think that this *initiative* would work if implemented in *another urban community*?** While the computerized immunization data system has been designed to meet the specific needs of Orange County, it is flexible enough in its design to utilize elsewhere. **Why?** As a matter of fact, it is capable of being easily modified to be operated on a PC for use in small providers' offices.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	Department of Health & Human Services, Municipality of Anchorage	City/State:	Anchorage, AK
Contact Person:	Delisa Culpepper	Telephone:	(907) 343-4622

1. What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)

Smoking cessation in pregnancy (SCIP).

2. Describe the *major accomplishments* of this initiative.

- Eliminate or reduce smoking during pregnancy by focusing on low-income women serviced through public health services.
- SCIP is the original project of University of Alabama Birmingham.
- Nutritional program for women, infants and children (WIC) and Prenatal Care II were programs used to solicit pregnant women.

3. How is it funded? City/County/Local government funds

What is the approximate total annual budget for this initiative? $20,000

4. What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?

Barrier 1: Determine perimeters of target population.	**How overcome?** Involvement of multiple agencies determined that low-income pregnant women did not have access to smoking cessation programs. To keep the program small, family members will not be actively involved in classes.

Barrier 2: Lack of education materials and program structure applicable to this target population.	**How overcome?** An existing successful program was chosen to be duplicated in our urban setting. The components that met our needs were educational materials of appropriate reading level and non-complex program structure.
Barrier 3: Verification of smoking cessation.	**How overcome?** A laboratory test was decided upon to verify cessation of smoking making this data compatible with the research project. Urine testing for cotinine is being used and will help to differentiate between second hand smoking tobacco used by the pregnant women.

5. How do you know this maternal and child health initiative has been *successful*?

This project is still new. However, the program in Alabama has demonstrated a "quit rate" that supports a successful project.

At this time, there is a good response from motivated population.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** 1) It is a short and simple program. 2) Cost effective because LBW is being prevented. 3) Cessation of smoking in pregnant women becomes a multi agency project and responsibility. 4) There is a reinforcing factor built into the program for the smoker through the referring agents.

1992 Urban Maternal and Child Health Leadership Conference

Health Department: City of Austin Health & Human Services Department/Travis County Health Department
City/State: Austin, TX

Contact Person: Ann Vetter RN
Telephone: (512) 469-2139

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Child abuse.

2. **Describe the *major accomplishments* of this initiative.**

   One sub-committee of the City's planning group addresses family violence. Members of this group have begun efforts in a long-term child abuse prevention effort for Austin/Travis County. A first-year public education plan is being designed to include media support and pro-bono assistance from the private sector. The cornerstone of this effort is based upon a research paper that recognizes child abuse as the common root of most youth and adolescent problems.

3. **How is it funded?** MCH block grant funds

   What is the approximate total annual budget for this initiative? $4,000.00

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**

Barrier 1: Public recognition of devastating results of child abuse on a community.	**How overcome?** Public awareness plan.
Barrier 2: Funding (Ongoing).	**How overcome?** Has not been resolved.
Barrier 3:	**How overcome?**

5. How do you know this maternal and child health initiative has been *successful*?

Has not been evaluated at this point. Interest from child abuse prevention providers is high.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?**

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	Baltimore City Health Department	City/State:	Baltimore, MD
Contact Person:	Dr Nira Bonner Dr Peter Beilenson	Telephone:	(410) 396-4452

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   The need to immunize students with Measles, Mumps, and Rubella (MMR) booster shots.

2. **Describe the *major accomplishments* of this initiative.**

   a) Provided information about immunization requirements to parents.

   b) Provided and easy mechanism for obtaining parental consent for their child's immunization. (Postcards with prepaid return postage were provided to parents).

   c) Provided immunizations at site easily accessible to students - their own schools.

   d) Although MMR booster shots were only recommended at the time, after this program 35% of sixth graders were immunized.

3. **How is it funded?** City/County/Local government funds

   What is the approximate total annual budget for this initiative? $20,000.00

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**

Barrier 1: Access to immunizations - difficult for youngsters to get to city-run immunization clinics.	**How overcome?** By providing immunizations at a student's school, access was provided to all but absentee students.

Barrier 2: Parental knowledge of need for these MMR booster shots.	**How overcome?** Parental notification letters were sent home by U.S. mail. In addition, Health Department personnel made appearances on local television and on public service announcements.
Barrier 3: Obtaining consent for immunizations for children without parents needing to appear at immunization site.	**How overcome?** Postcard with prepaid return postage was sent to parents. There was room on the card for parents to note child's name, school, and whether they had already received an MMR booster shot. In addition, there was a space for parents to provide their signed consent. (Cards were then mailed back to the Health Department where they were collated by school and school nurses conducted single-day immunization clinics at each middle school.

5. **How do you know this maternal and child health initiative has been *successful*?**

   Over 35% of sixth graders with this recommended MMR booster shot through this campaign. Although we are the poorest major jurisdiction in Maryland, our school-based immunization program with mailed consent cards immunized a greater percentage of sixth graders than any other major jurisdiction with their traditional clinic-based program. With Maryland now requiring an MMR booster for entering kindergartners and sixth graders, we anticipate that our booster program participation rate will increase significantly.

6. **Do you think that this *initiative* would work if implemented in *another urban community*?** Yes **Why?** This school-based immunization program would be easy to replicate in any city in the country where school nurses are available.

1992 Urban Maternal and Child Health Leadership Conference

Health Department: Louisiana State Dept of Health City/State: Baton Rouge, LA
Contact Person: Teen Advocate Program Telephone: (504) 927-9810

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   The Teen Advocate Program, a case management demonstration project funded by MCH block grant and Family Planning Program and contracted out to Family Counseling Services, Inc. addresses teen pregnancy, low birth weight and teen pregnancy prevention.

   Medical services, parental skills training and encouragement and assistance to complete education and training are provided.

2. **Describe the *major accomplishments* of this initiative.**

   1) One RN, one masters level social worker and one masters level counselor have provided outreach case management services since October, 1987. Current statistics show that for the period of 10-1-91 to 4-30-92 case management services have been provided to 433 teens - 152 family planning cases and 281 pregnant teens.

   2) National repeat teen pregnancy rate is 22%. Our repeat pregnancy rate is 1% for the same period (10-1-91/4-30-92).

   3) Level of change in the Goal Attainment Scale was 8.09 decrease in problem areas.

   4) In a parish where sex education is not usually allowed, we have done classes on abstinence, anatomy, birth control and sexually transmitted disease education. Total 22 group sessions - approximately 566 teens reached.

3. **How is it funded?** MCH block grant funds; Other Federal Funds (Family Planning Program);

   What is the approximate total annual budget for this initiative? $141,000

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**	
Barrier 1: Transportation for medical services and to attend groups we had planned on pregnancy and parenting skills.	**How overcome?** We used money donated to our program to buy bus tokens to give to the girls.
Barrier 2: Getting family planning and adolescent clinic appointments in a timely fashion.	**How overcome?** Due to a shortage of personnel and funding in LA this problem is not completely solved yet. At this time, we have worked out a system that allows us to take a list of girls who need appointments to a clerical worker and she will see that appointments are scheduled but there may be a 4-5 month waiting period for family planning.
Barrier 3:	**How overcome?**

5. **How do you know this maternal and child health initiative has been *successful*?**

At intake, an initial assessment is done using a ten factor screening instrument and goal attainment scale. This same instrument and GAS are repeated for a closing assessment. The two scores are then compared to see how much and in what areas the problems have decreased. At closure, the teen is sent a program evaluation sheet so that they may evaluate us and we can see how they viewed the program and where, if any, improvements or changes can be made. The teens are asked not to include their name on the evaluation so that they may be perfectly honest.

6. **Do you think that this *initiative* would work if implemented in *another urban community*?** I feel that this initiative will work anywhere if the worker likes and cares for teens and knows the resources available. Adolescents have been the forgotten generation and we are reaping the results. **Why?** It will work because our teens need help!

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	Jefferson County Dept of Health	City/State:	Birmingham, AL
Contact Person:	Mary Ann Pass MD MPH Deputy Health Officer	Telephone:	(205) 930-1502

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   This initiative addresses the problems of increasing incidence of breast-feeding among low income women.

2. **Describe the *major accomplishments* of this initiative.**

   Through the use of a peer group discussion and support program, the initiative increased the number of low-income women who breast-feed. The group includes prenatal patients, women currently breast-feeding and their babies. Since child care is a problem, other children also are invited. Depending on the number and ages, they can go to another room and be read to by a volunteer or play with donated toys in the meeting room. Support persons such as fathers and grandmothers also attend.

   The meeting are held in a public library conference room which provides a social, relaxed environment. The atmosphere encourages women to share their experiences with each other. The breast-feeding counselor serves as facilitator and provides a short presentation to initiate discussion at each meeting. The series includes four sessions, but many mothers continue to participate series after series because they enjoy receiving and providing support from their peers.

   This initiative demonstrates that a support group environment provided for low-income women in which they help each other through shared experiences and support can increase the number of women who breast-feed.

3. **How is it funded?** Other Federal funds

   What is the approximate total annual budget for this initiative? $2,000.00

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**	
Barrier 1: Finding an appropriate place for the group to meet on a regular basis.	**How overcome?** Talked to patients and found out places they recommended. Tried several sites including housing project, community center and churches. Library wasn't first choice, but it worked out to be the most centrally located and neutral setting. They had a room where the group meets on a regular basis and space for older children's activities.
Barrier 2: Finding someone to watch the older children on a regular basis so that the mothers could focus on the group.	**How overcome?** Library personnel couldn't be used to watch the children, but arrangements were made for a city park employee to assist when more than two older children are present. Students have also been used to assist with children, but aren't always available. This continues to be a problem on some days.
Barrier 3: Not being able to pay peer counselors to assist with meeting and provide support outside of the meetings.	**How overcome?** Demonstrated to the Birmingham Healthy Start grant the effectiveness of using peer support staff and plans are to provide payment through this grant for peer support counselors at all centers.

5. How do you know this maternal and child health initiative has been *successful*?

At baseline, the health center associated with this initiative had fewer new breast-feeding women than the department's other major health centers. For the two years following baseline, this center had more than doubled the number of new breast-feeding women as the other major centers. During this time all centers provided some other services: breast-feeding counselor through clinic system, lending library and pamphlets.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** Low in-come women need and will participate in a breast-feeding support and discussion group. They increase their self-confidence to successfully breast-feed through the interaction and shared experiences with their peers.

1992 Urban Maternal and Child Health Leadership Conference

Health Department: Central District Health Dept
Contact Person: Kathy Holley
City/State: Boise, ID
Telephone: (208) 375-5211

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Early entry into prenatal care and access to prenatal care.

2. **Describe the *major accomplishments* of this initiative.**

   CDHD entered into a cooperative effort with private practice obstetricians, family practice physicians, Family Practice Residency Program, and local hospital to improve access to prenatal care in the first trimester. CDHD is the single access point for pregnant women without physicians. Any woman can receive a pregnancy test, Medicaid Presumptive Eligibility determination, and be given their first appointment for prenatal care with the Residency Program or private physicians.

   This effort has been ongoing for two years. We have seen an increase in early entry into prenatal care as reported on the birth certificate of 2.4% the first year of the project (79.3% in 1989 as compared to 81.7% in 1990 receiving prenatal care in the first trimester). We have indications of up to an additional 5% increase for the second year.

   This project has made life much simpler for the clients and has improved communications between private and public sector. Three other projects have spun off of this original project.

3. **How is it funded?** City/County/Local government funds; General state funds; MCH block grant funds; Third party reimbursement (Medicaid, insurance).

   What is the approximate total annual budget for this initiative? $278,074.00

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**	
Barrier 1: Hesitancy by all players to commit to untried concept.	**How overcome?** a) Lots of joint meetings. b) Commitment made up front by Family Practice Residency and Health Department. c) Open discussions with issues put on table. d) Staff level commitment in all agencies with formation of coalition of agencies to work out problems at the 'workers level.'
Barrier 2:	**How overcome?**
Barrier 3:	**How overcome?**

5. **How do you know this maternal and child health initiative has been *successful*?**
Increase in early access to prenatal care.

6. **Do you think that this *initiative* would work if implemented in *another urban community*?** Yes **Why?** Joint venture which shared the financial burden among vested parties.

1992 Urban Maternal and Child Health Leadership Conference

Health Department: Boston Dept of Health & Hospitals City/State: Boston, MA
Contact Person: Lillian Shirley Telephone: (617) 534-5515

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   The initiative addresses the need to improve the health and development of Boston's high risk children of low birth weight by focusing interventions in the home and targeting the whole family service.

2. **Describe the *major accomplishments* of this initiative.**

   - Assessing the medical and social needs of young children and families.
   - Providing medical advocacy liaison for families.
   - Ability to address transition from hospitalization to community.
   - Intervening with children in the home allows integration with teaching home safety, parenting skills curriculum, grandmother and grandfather's groups in addition to maternal and child focus.

   - Promoted collaboration between health care agencies and provider: Primary care pediatricians, home visitor, specialty clinics and social service agencies.

3. **How is it funded?** City/County/Local government funds; Boston Foundation; FY '93 - host MCH block grant.

   What is the approximate total annual budget for this initiative? $670,959.00

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**

Barrier 1: Available support services e.g.: Mental Health, Parent Aide Services, respite care. A complicated reimbursement system.	**How overcome?** Donations for various support activities from community organizations and third party billing to be implemented by Jan. '93. Support through groups.

Barrier 2: Urban Isolation, many of our families are alone without proper financial resources, supportive family and community resources.	**How overcome?** We implemented support groups for our families, ie, a summer one day a week parent/child camp. Peer Support group, Haitian teen support group, Fathers group for Latino parents, Pregnant Teen group. Parenting groups at church bases in neighborhoods.
Barrier 3: Transportation. Lack of access to transportation to get to needed medical appointments, community support resources.	**How overcome?** The program provides emergency cab vouchers, we provide transportation for our summer Day Parent/Child Camp. We are helping families that are eligible, get vouchers for the medical Assistance Program.

5. **How do you know this maternal and child health initiative has been *successful*?**

   Increased client attendance involvement in neighborhood health centers. Decreased child neglect and abuse reports in families followed for more than 6 months. Increase in stable housing for clients.

6. **Do you think that this *initiative* would work if implemented in *another urban community*?** Yes **Why?** Because direct involvement in the home with the families give programs a chance to develop needed relationship to work with families advocate for them and impact changes in their lives. Urban settings often have many services, but fragmentation decreases access. A program like Healthy Child seeks to collaborate and integrate services, not replicate existing providers.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	Mecklenburg County Health Dept	City/State:	Charlotte, NC
Contact Person:	Betty Snow	Telephone:	(704 336-4701

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Adolescent pregnancy, access to health care, juvenile delinquency and violence, school drop-out, substance abuse, physical and mental abuse.

2. **Describe the *major accomplishments* of this initiative.**

   - Initiation, implementation, and evaluation of a multi-disciplinary, comprehensive, community based program that assists at-risk youth to make positive choices.
   - Case management services for a targeted population that includes family centered social work.
   - Health assessments for youth with appropriate referral, follow-up, and care.
   - Provision of mental health counseling utilizing individual as well as, group programming.
   - Mentorships for youth and families.
   - Tutoring services that include homework help.
   - Health education that incorporates skill building in the areas of conflict resolution and stress management.
   - Provision of after-school enrichment experience.
   - Family focused programming that values cultural diversity.
   - Community service projects.
   - Support groups that focus on building self-esteem, human sexuality, values exploration, and assertiveness training.

3. **How is it funded?** City/County/Local government funds

   What is the approximate total annual budget for this initiative? $200.000.00

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**	
Barrier 1: Working in partnership with a variety of community agencies and resources.	**How overcome?** Formation of an advisory board and partners coalition to plan and evaluate the project. Establishment of clearly defined goals and objectives. A commitment from all involved to focus on the needs of the children and families.
Barrier 2: Lack of volunteers to assist with program activities.	**How overcome?** Establishment of a volunteer coordinator to recruit volunteers from multiple sources: corporations, colleges, churches, etc. Persistent efforts in making presentations to various organizations and clubs. Utilizing a community recruitment fair. Facilitating a media campaign about the project.
Barrier 3: Availability of space and incentives for project programming.	**How overcome?** Collaboration with local school system and YMCA to secure space and support for activities. Working closely with a Cities-in-Schools Program and local merchants to solicit incentives for project participants who met individual and group goals.

5. How do you know this maternal and child health initiative has been *successful*?

Preliminary evaluations validate positive impact. One of the primary efforts of Project HOPE is to increase the assertiveness of youth in order to "equip" them to make positive life-style choices. Pre-test and post-test comparisons of students in HOPE and a group of similar students not in Project HOPE indicate that those in Project HOPE increased their assertiveness ability by 9% while those in the comparison group increased by only 1%. Initial evaluations also show early identification of health care problems and facilitation of access to care for those conditions.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** It is a collaborative, community based model that focuses on realistic and measurable program objectives and outcomes. It is also designed to utilize various disciplines that focus on empowering youth and families.

1992 Urban Maternal and Child Health Leadership Conference

Health Department: Chicago Dept of Health
Contact Person: Shirley Fleming
City/State: Chicago, IL
Telephone: (312) 744-8483

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   The Maternal and Child Health problem that this initiative addresses is access to health care.

2. **Describe the *major accomplishments* of this initiative.**

   The health care project is a public/private partnership that was initiated to increase patient access to health care services. Project funds are used to hire Linkage Coordinators who work within the facilities that are operated by the participating partners.

   The following is a list of major accomplishments that this initiative has achieved:

   1. Decreased patients wait time for new appointments.
   2. Provided patients with access to specialized services that were not offered by their provider (e.g. dental, mammography).
   3. Increased communication between the participating agencies.
   4. Fostered public/private coordination in caring for poor women and children.

3. **How is it funded?** City/County/Local government funds/Foundation funding

   What is the approximate total annual budget for this initiative? $200,000.00

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**	
Barrier 1: Some patients have been reluctant to be referred to an "unfamiliar" health care facility.	**How overcome?** The Linkage Coordinator follows-up carefully and caringly educates patients about the referral site and procedures. Follow-up is also done to determine if patients have a positive health care experience and corrective action is implemented when indicated.
Barrier 2: Communication between referral partners has sometimes become uncoordinated due to staff absence or failure to receive referral information in a timely manner.	**How overcome?** An alternate Linkage Coordinator was designated at each facility. Basic referral and patient information are communicated by fax.
Barrier 3: Occasionally patients demand/need for services exceed the capacity of participating agencies.	**How overcome?** The Linkage Coordinator frequently communicates information about the capacity at each site.

5. **How do you know this maternal and child health initiative has been *successful*?**

   Through monitoring patients wait time, we have noted a one (1) to two (2) week decrease in the next available appointment. Patients have gained access to services not available at their regular primary care provider.

6. **Do you think that this *initiative* would work if implemented in *another urban community*?** Certainly. **Why?** The referral program is technically simple, requiring primarily cooperation among health care organizations and minimal funding.

1992 Urban Maternal and Child Health Leadership Conference

Health Department: Cincinnati Health Dept
Contact Person: Judith S Daniels MD MPH
City/State: Cincinnati, OH
Telephone: (513) 352-3189

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Infant Mortality.

2. **Describe the *major accomplishments* of this initiative.**

   Since 1990, the Child and Family Health Services' (CFHS) Pediatric Tracking Program has followed children who were delivered at Cincinnati's University Hospital to women with poor prenatal care.

   The families, 350 per year, are poor, 77% African-American, and reside in a few well-defined neighborhoods. Forty-four percent (44%) of the children do not keep their first well-child care appointment and 35% have no contact with the health care system through the first year of life.

   The low birth weight rate (24%) and infant mortality rate (37/1000) live births) are more than 3-fold greater than our regional averages. It is clear that the present health care delivery system is not suited to the needs of these extremely high risk families.

   This initiative's major accomplishment has been to identify these high risk families so that special intense efforts can be targeted to their needs in order to improve these poor outcomes.

3. **How is it funded?** MCH Block Grant funds - Other: University of Cincinnati Dept. of Pediatrics

   What is the approximate total annual budget for this initiative? $35,000.00

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**

Barrier 1: More infants were born under these conditions than was first projected.	**How overcome?** Additional funds are being sought to expand these services to all eligible mothers.

Barrier 2: Even with our Public Health Nurse visit, many children did not get well-child care.	**How overcome?** Additional public health referrals have been made.
Barrier 3: Even after entering care, many children fail to complete immunizations on time.	**How overcome?** An immunization tracking program is being implemented which can be accessed in any clinic or the Children's Hospital Emergency Room in order to decrease missed opportunities with these children.

5. How do you know this maternal and child health initiative has been *successful*?

The initiative has been successful in the identification of these high risk families. The intense services being provided will have to be assessed to determine success in outcomes.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** The tracking mechanism can be duplicated if funds are available.

1992 Urban Maternal and Child Health Leadership Conference

Health Department: Cleveland Dept of Public Health | City/State: Cleveland, OH
Contact Person: Karen K Butler | Telephone: (216) 664-2324

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Infant Mortality Reduction.

2. **Describe the *major accomplishments* of this initiative.**

   This effort represents a first for interorganizational program integration in Cleveland. Involved are a broad array of health care providers, at primary, acute and tertiary care levels, support service agencies, neighborhood residents, educators, researchers, and public and private leaders. All have joined together at an unprecedented level of cooperation to integrate programs, organize resources, and build on effective models to attack public health problems associated with infant mortality.

3. **How is it funded?** City/County/Local government funds

   What is the approximate total annual budget for this initiative? $4 Million

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**

Barrier 1: Lack of supportive services for clients.	**How overcome?** Developed a means of providing child care, transportation and assistance through collaboration with other agencies.
Barrier 2: Lack of service coordination.	**How overcome?** This initiative was instrumental in establishing a city-wide consortium of service providers to work together to eliminate the duplication and fragmentation of services.

Barrier 3: Difficulty in recruitment of outreach workers.	**How overcome?** Job Training Program for outreach workers which provided incentives to encourage participation of community residents.

5. How do you know this maternal and child health initiative has been *successful*?

Collaborating agencies which are part of this initiative have demonstrated tremendous success in impacting upon high infant mortality rates. One program, in particular, has reduced the IMR in one of its targeted areas by 46%.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** This initiative can definitely be successful in other urban communities which are faced with the same health concerns which exist in Cleveland.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	El Paso County Department of Health and Environment	City/State:	Colorado Springs, CO
Contact Person:	Betty McLain	Telephone:	(719) 578-3212

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Ultimately, to achieve improvements in prenatal outcomes; initially to develop models for enhanced prenatal services. Colorado Medicaid does not provide these services.

2. **Describe the *major accomplishments* of this initiative.**

   Services provided: care coordination by public health nurses including assessment of the participant's medical, nutritional, psychosocial, educational and financial needs; advocacy; referral to community resources and follow-up; outreach and case-finding. The staff includes: public health nurses, a social worker and a dietician. Prenatal medical services are provided by nurse practitioners. During the pilot project 320 participants will be served. As of July 31,1992, 309 women had enrolled in the project. Of this group 50% of the women enrolled during their first trimester. The mean week of pregnancy in which care coordination began was 15 weeks. Major accomplishments:

   1. Integration of WIC services and issuance of WIC checks during participants initial visit to clinic.
   2. Availability of interpreter services for Spanish speaking clients.
   3. Funding for transportation provided by community service organization.
   4. Networking with Drug and Alcohol Clinic to provide services for participants with substance abuse.
   5. Obtaining medical appointment for all participants within 2 weeks of entering the project.
   6. Home visits by public health nurses prenatally and within 48 hours of discharge from hospital.
   7. Public health nurse follow-up for pregnancy testing done at the Health Department.

   Of this group of women who have delivered (81), two women delivered LBW babies at 37 weeks and 7 delivered LBW following pre-term labor due to significant medical problems.

3. **How is it funded?** MCH block grant funds

   What is the approximate total annual budget for this initiative? $80,000.00

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**	
Barrier 1: Lack of transportation.	**How overcome?** Networking with community action agency who contacted service organization interested in providing funding for a "need" within the community. Service organization agreed to provide monies for transportation to be used.
Barrier 2: Lack of coordination of services between WIC and prenatal clinic. Both services provided in the same building.	**How overcome?** Integration of WIC nutritionist into prenatal clinic allowing WIC checks to be issued at initial prenatal appointment.
Barrier 3: Inability to obtain prenatal care within a two week period.	**How overcome?** Documented this barrier and then presented data to clinic manager. Clinic staff implemented changes thus eliminating barrier.

5. How do you know this maternal and child health initiative has been *successful*?

The project will be successful in obtaining funding for enhanced services through the Colorado state legislature. However, the major accomplishments involve advocating for the participant to eliminate barriers to services thus assisting pregnant women to obtain a variety of services for which she may be eligible.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Why?

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	Columbus Health Department	City/State:	Columbus, OH
Contact Person:	Carolyn B Slack MS RN	Telephone:	(614) 645-6424

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Infant Mortality.

2. **Describe the *major accomplishments* of this initiative.**

   Colombus, Ohio has convened a Leadership Council to reduce infant mortality. The council convenors are the Columbus Health Department, March of Dimes, Academy of Medicine (local medical society), the six (6) delivery and the Children's Hospitals.

   The purpose of the council is to reduce infant mortality by bringing together appropriate providers, payors, policy makers and special interest groups who can create a common vision and develop an action plan for the future. After nearly 12 months of planning, the first council meeting was held in March, 1992. Five action-oriented Task Teams met for the first time that evening and special projects have continued since then. The major accomplishment was, for the first time to have all the players around the table.

3. **How is it funded?** Staff time from all organizations small amounts to cover meetings and facilitator consultants.

   What is the approximate total annual budget for this initiative?

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**

Barrier 1: Lack of useable information about our service system for pregnant women.	**How overcome?** A survey was developed and sent to all "public" prenatal clinics, all delivering hospitals and private physicians. Data were collected, analyzed and presented at the first council meeting. These data were a baseline for project development.

Barrier 2: Infant mortality issue is huge. In order to keep focused, we needed to develop a structure to define how we could work together to reduce infant mortality.	**How overcome?** As a result of the survey findings, five task teams were created. They are: 1. Reduce waiting times and no shows. 2. Promote early prenatal care. 3. Establish a cooperative continuum of care. 4. Enhance the role of Medicaid in MCH services. 5. Assure comprehensive services for pregnant women.
Barrier 3: How do we (convenors) maintain this initiative, how do we maintain a communication among all, make decisions, etc.	**How overcome?** We are working (with a consultant) on how to structure ourselves to achieve our goal. The council is growing - both in terms of participants and projects. At this time, we have no funding. Individual organizations provide "support" to their respective convenors.

5. How do you know this maternal and child health initiative has been *successful*?

We have been able to maintain active participation of the major players. Projects are moving forward which will improve the system care. Even though hospitals are "in competition," all are participating in cooperating to reduce infant mortality.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** The process of bringing all players together in one room with a shared goal constitutes a success. The momentum of this "success" will contribute to the continuing commitment of the players and the implementation of the action plans to reduce Infant Mortality.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	Corpus Christi-Nueces County Health Department	City/State:	Corpus Christi, TX
Contact Person:	Annette Sultemeier	Telephone:	(512) 851-7260

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Our current Maternal Infant Health Improvement Act Program (MIHIA) is carrying a caseload of 2,000 high risk pregnant women and infants for case management. We have just begun the same with our women with normal pregnancies.

2. **Describe the *major accomplishments* of this initiative.**

   Per State mandate and additional funding case management was established about 1 1/2 years ago. It begins when a women with a high risk pregnancy enters the system and continues through the infants first year of life. Because of our effort we have acquired additional staff and a computer network. Contrary to initial belief the clients are receptive and for the most part compliant. The end results are women entering prenatal care sooner (62%) 1st trimester) and healthier pregnancy outcomes. women are more likely to receive family planning services if under case management.

   Approximately six (6) months ago, case management was begun for women with normal pregnancies attending our clinics. This will be expanded to those women who have Medicaid and choose to see a private physician. Education and counseling can be provided while possibly missed otherwise.

3. **How is it funded?** City/County/Local government funds - Third party reimbursement (Medicaid, insurance)

   What is the approximate total annual budget for this initiative? Approximately: $750,000.00

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**	
Barrier 1: Initially more women were being admitted in the 2nd and 3rd trimesters of pregnancy.	**How overcome?** Are doing pregnancy testing on a walk-in basis. Increased staff so time is less to get an appointment. Women with positive pregnancy test can get an appointment for admission within a few days.
Barrier 2: Transportation to clinics or doctor's office.	**How overcome?** Provide transportation or bus tokens to the bus.
Barrier 3: Fragmentation of social services available to a client.	**How overcome?** Now fill out Medicaid forms and an integrated eligibility so clients can be referred on admission to services that are needed.

5. How do you know this maternal and child health initiative has been *successful*?

Caseload has grown, more staff has been hired and pregnancy outcomes are better.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** Case management is an old revived concept and really gets staff into the community where the best overall good can be done.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	City of Dallas Health & Human Services	City/State:	Dallas, TX
Contact Person:	Anna Hawkins RN	Telephone:	(214) 670-8266

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Low birth weight (LBW) and infant morbidity and mortality.

2. **Describe the *major accomplishments* of this initiative.**

   While extensive efforts are directed towards reducing infant mortality and pre-term births, low birth weight (< 1600 gms) infants continue to be born. LBW infants are at high risk for child abuse, neglect, developmental delays and physically handicapping/life threatening chronic conditions.

   The city of Dallas LBW Program began in 1985 in response to the critical needs of LBW babies and their families for whom there were no services available. To date, 554 LBW infants have been enrolled, 88% of whom are minority. The LBW clinic averages 1,000 visits per year. Babies in this program require intensive follow-up during the first 18 to 36 months of life which includes health education, developmental screenings, counseling, aggressive assessment and treatment of potential high risk medical problems, and early referral where indicated. Staff includes 2 part-time MD's and 1 full-time case manager RN, 1 Pediatric Nurse Practitioner, 1 RN, and 1 Clerk.

   Periodic home visits identify problems and provide support and crisis intervention to these high risk families. A concerted effort is made by staff to build rapport with each family, to be culturally sensitive, and to make services user friendly. The LBW staff work closely with a newly funded High Risk Case Management Program available to assist clients access services.

3. **How is it funded?** City/County/Local government funds - Third Party reimbursement (Medicaid, insurance)

   What is the approximate total annual budget for this initiative? $184,530.00

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**	
Barrier 1: Funding for staff positions. Program operated for 1st 2 years with one (1) full-time RN and one (1) part-time M.D.	**How overcome?** March of Dimes Grant provided 3 year funding for 2 additional positions - 1 pediatric nurse practitioner and one clerk. Because of the March of Dimes commitment to the LBW Program, the City of Dallas provided funding for an additional RN position.
Barrier 2: Data collection and analysis.	**How overcome?** A dBase computer program is used to collect individual patient data in three primary areas: 1. Prenatal/social history 2. Clinic Visits 3. Home Visits This system has proven invaluable in documenting program's success and dollars saved to community.
Barrier 3:	**How overcome?**

5. How do you know this maternal and child health initiative has been *successful*?

5-10% re-hospitalization rate vs. 40% national average. In 1991, cost savings for early detection and treatment of respiratory problems in these infants is estimated to be $130,000 based on out patient services. Because of documented program success, the City of Dallas continued to fund positions when the March of Dimes grant expired.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** Very low birth weight infants continue to be born; public health has the experience and resources necessary to address the frequent overwhelming social complications facing families with very low birth weight infants.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	Combined Health District of Montgomery County	City/State:	Dayton, OH
Contact Person:	Frederick L Steed	Telephone:	(513) 225-4966

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Access to Health Care: Informed Consent/Treatment of Minors.

2. **Describe the *major accomplishments* of this initiative.**

   Changes in the social fabric of our society are making the provision of health services to selected populations more challenging. Situations are becoming more frequent when a minor presents for care without a parent or legal guardian, but in the custody of another blood relative or family friend. Strict interpretation of the law would prevent us from providing treatment to these minors. However, the Health District has a legal and moral obligation to provide the appropriate care to minors on demand; notwithstanding informed parental/guardian consent vs. a necessary legal barrier. In order to facilitate appropriate health services to minors, the Health District's Board adopted a written policy for health care providers with detailed protocol for decision making and documentation which would minimize employee legal liability and allow us to meet our public health mission.

3. **How is it funded?** City/County/Local government funds - Third party reimbursement (Medicaid, insurance)

   What is the approximate total annual budget for this initiative? Within scope of existing budget.

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**

Barrier 1: To develop a policy that would be comprehensive and yet easily implemented.	**How overcome?** A committee was formed consisting of clinical and management staff from all service areas within the Health District to develop the policy. This effort was assisted by the District's legal counsel to assure medical and legal requirements were compatible.

Barrier 2: The education of the Health Commissioner and District Board members of the necessity for such a policy.	**How overcome?** One-on-One education of each Board member to address their concerns of the need for such a policy including agency and personal legal liability.
Barrier 3: To get the clinical staff to become comfortable with the policy which addressed their concern of legal liability in the event of a lawsuit.	**How overcome?** The clinical staff was involved throughout the developmental phase of the policy. They were given an opportunity to discuss and make suggestions regarding the policy up to the time of adoption by the Board. Finally, clinical staff was charged with developing the operational procedures to implement the policy.

5. **How do you know this maternal and child health initiative has been *successful*?**

   The policy/procedure is to be implemented September 14, 1992, so its success is yet to be determined. Feedback from staff indicates that the policy is being received very positively and needed to reduce the barrier created by Informed Consent issues.

6. **Do you think that this *initiative* would work if implemented in *another urban community*?** Yes **Why?** Once the terminology is defined and certain critical questions considered, the issue of consent can be resolved quickly by utilizing written policies and procedures.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	Denver Dept of Health & Hospitals	City/State:	Denver, CO
Contact Person:	Paul Melinkovich MD	Telephone:	(303) 436-6690

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Access to care.

2. **Describe the *major accomplishments* of this initiative.**

   a. Establishment of a collaborative planning process between the health department, the public schools and the Children's Hospital to expand school based and school linked health issues.

   b. Provisions of primary health services to students at these public high schools.

   c. Planned expansion of services during 1992-93 academic year to one additional high school, one middle school and five elementary schools in an area of the city currently lacking readily available public or private health services.

   d. Commitment of financial and in-kind support from the major partners for the planned expansion.

3. **How is it funded?** City/County/Local government funds, MCH block grant funds, 330 funds, Private hospital, University Health Sciences Center, Third party reimbursement (Medicaid, insurance).

   What is the approximate total annual budget for this initiative? $1,361,418.00

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**

Barrier 1: Getting major participants to work together and support initiative.	**How overcome?** Laborious process of planning meetings to assure partners that their concerns were addressed. Ground work for the process included a council on health appointed by school administration.

Barrier 2: Obtaining staff support planning process.	**How overcome?** Receipt of MCHIP planning grant to implement the project.
Barrier 3:	**How overcome?**

5. How do you know this maternal and child health initiative has been *successful*?

This is the first time partners have been able to agree to work together and identify new funds for health service delivery. This is a major success.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** Major new initiative in maternal child health will require collaboration among a number of partners.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	Detroit Department of Health	City/State:	Detroit, MI
Contact Person:	Stella Bayless	Telephone:	(313) 876-4333

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Increasing preschool and school age immunization levels.

2. **Describe the *major accomplishments* of this initiative.**

   Low morbidity for vaccine preventable diseases due to: Enforcement of State Immunization law which requires all entrants into public/private schools and day centers within Detroit to be immunized based on student, antigen and date specific criteria.

   All entrants' immunization records are entered into Detroit Health Department computer and issues notices of exclusion twice a year. By the end of the school year, 96% of kindergarten students and 97% of preschoolers are in compliance with requirements. MMR Levels are 98% for kindergarten and 94% for preschoolers.

   Distribution of vaccine to private providers for the Medicaid and medically-indigent patients. Private sector provides immunizations to an estimated 70-75% of population. Replacement of Medicaid/medically indigent doses is a major factor in maintaining this private sector commitment.

3. **How is it funded?** City/County/Local government funds, Other Federal funds, Third party reimbursement (Medicaid, insurance)

   What is the approximate total annual budget for this initiative?

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**

Barrier 1: Timely listing of children who need to be excluded and antigens needed to bring them in compliance.	**How overcome?** Computerization of all preschool and school age immunization records.

Barrier 2: Lack of sources for parents to obtain immunizations on the days of exclusions.	**How overcome?** 1) Established walk-in immunization clinics by the Detroit Health Department. 2) Established written policy for multiple dose administration by Detroit Health Department.
Barrier 3:	**How overcome?**

5. How do you know this maternal and child health initiative has been *successful*?

Higher percentage of kindergarten students and preschooler are in compliance with requirements by the end of the school year.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** It requires a collaborative relationship among the State/Local Health Departments and the private sector which probably already exists.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	El Paso City-County Health District	City/State:	El Paso, TX
Contact Person:	Martha Quiroga Case Management Coordinator	Telephone:	(915) 543-3539

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   The coordination of case management activities of high risk maternity clients and/or infants to avoid duplication within the county and to initiate Medicaid billing for these services.

2. **Describe the *major accomplishments* of this initiative.**

   One major accomplishment of this initiative was the establishment of a liaison for each of the 14 agencies represented to serve as the case management contact. Another major accomplishment was the Memorandum of Understanding (M.O.U) which each agency signed to indicate the written commitment to coordinate case management activities. Finally, the best accomplishment was the re-establishment of a consortium providing a foundation for communication among agencies serving high-risk perinatal clients.

3. **How is it funded?** Funding was not provided for this consortium

   What is the approximate total annual budget for this initiative? --

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**

Barrier 1: The resignation of one of the main community leaders who spearheaded the formation of consortium occurred in April, 1992.	**How overcome?** The coordination of this project was reassigned to myself. Through the prioritization of needs I rearranged my schedule with the help of my supervisor. The Social Service Supervisor became by partner in the coordination of this project. This provided two individuals who managed the monthly meetings, notified the agencies of any changes, and completed the M.O.U. on time.

Barrier 2: One agency which receives referral from all other agencies on the consortium had its funding terminated and reassigned to another source.	**How overcome?** As much as possible assistance was provided to this director who is unfamiliar with the community resources and with the concept of case management itself. Funding source is being reestablished and decisions regarding case management activities were stated in the M.O.U.
Barrier 3: There was initially a general lack of commitment to participating in the M.O.U due to the inability to provide case management services as required by the Texas Department of Health.	**How overcome?** The TDE Case Management Staff came from Austin at least 3 times to present the rationalization for initiating case management services as a billable item under Medicaid. As clinics had a change in staffing the meetings became a clearinghouse for update on changes at the state level which, in turn, would effect those at the local level. This led to the formation of the consortium.

5. **How do you know this maternal and child health initiative has been *successful*?**

   The success of this initiative is demonstrated in the M.O.U., the list of case management responsibilities per agency, and signature pages which any participating agency can use to submit their own application for authorization for case management billing. Further evaluation of this effort is pending.

6. **Do you think that this *initiative* would work if implemented in *another urban community*?** This initiative could work in any community as long as there is funding available for case management services of a particular population. **Why?** Also the fact that this effort has been mandated through the legislative bodies of Texas is powerful source of motivation! This has been one result of consolidation of agencies at the state level.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	Fort Worth/Tarrant County Public Health Department	City/State:	Fort Worth, TX
Contact Person:	Glenda Thompson RN	Telephone:	(817) 871-7209

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Low immunization rates among inner city preschoolers.

2. **Describe the *major accomplishments* of this initiative.**

   To meet the goal of providing immunizations in high risk target areas, the Immunization Outreach Team has conducted immunization clinics in shopping malls, community centers, public housing projects, shelters, churches, day care centers, WIC clinics, AFDC offices, and other community sites.

   The Junior Leagues of Fort Worth and Arlington provide volunteer support, assist in manual data collection, provide funds for equipment and printing flyers, and act as a liaison between the public health department and businesses and individuals.

   Kroger Food Stores provide advertising and treats for the children immunized at the outreach locations. In addition to providing space for immunization clinics, area shopping malls assist with advertising, and provide discount coupons for incentives to obtain immunizations.

3. **How is it funded?** General State funds

   What is the approximate total annual budget for this initiative? $125,000.00

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**

Barrier 1: Staffing.	**How overcome?** We decided to have Licensed Vocational Nurses instead of Registered Nurses to provide the services. The coordinator of the program is also a Licensed Vocational Nurse.

Barrier 2: Transportation.	**How overcome?** Two vans were purchased to transport staff and supplies to sites, allowing for quick set-up of clinics.
Barrier 3: Publicity/Education.	**How overcome?** Collaboration with private and public entities to provide publicity, supplies, volunteers and discount coupons for incentives.

5. **How do you know this maternal and child health initiative has been *successful*?**

   In the first nine months of operation (January-September, 1991), the Immunization Outreach Team provided immunizations to 5,739 children and referred another 4,294 to other social service agencies or health care providers. The efforts of this program played a vital role in decreasing the number of confirmed measles in Tarrant County. (300 in 1990 to under 10 in 1991).

6. **Do you think that this *initiative* would work if implemented in *another urban community*?** Yes **Why?** All cities have high risk target areas in need of immunization services. The mobile team is easy to initiate. If low cost workers are used, the mobile team is also cost effective.

1992 Urban Maternal and Child Health Leadership Conference

Health Department: Kent County Health Department City/State: Grand Rapids, MI
Contact Person: Mary Beth Meijer Telephone: (616) 774-3943

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   The Forum on Prenatal and Infant Care was initiated in response to high infant mortality rates in Kent County.

2. **Describe the *major accomplishments* of this initiative.**

   A. A set of guiding principles and values were developed by the community.

   B. Over 70 community leaders remain committed to implementing the Forum Recommendations.

   C. Three Neighborhood Center sites are being developed.

   D. Cooperation between existing agencies is much improved. i.e. Clinic waiting lists for entry into prenatal care have decreased from an 8 week waiting list to 2-3 weeks county wide.

   E. Cultural sensitivity training is being recommended and accepted by the health care community.

3. **How is it funded?** Private local foundations, Participating hospitals and social agencies, /Third party reimbursement (Medicaid, insurance)

   What is the approximate total annual budget for this initiative?

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**

Barrier 1: Build in a permanent funding base.	**How overcome?** We will continue to cope with this problem throughout its implementation. Our initial plan is to expand the FQHC (Federal Qualified Health Center) model, to try to cover treatment at cost.

Barrier 2: Information and cultural sensitivity gaps between the professional community and the client population.	**How overcome?** Cultural sensitivity training is being recommended to the professional implementation staff. Cultural sensitivity training is required of all staff working in neighborhood centers. Actual users of the system, clients are involved in the implementation and planning process.
Barrier 3: Determination of the best agency to ultimately coordinate and oversee the project.	**How overcome?** The coordinating and oversight agency must be one that is truly community driven, trusted, and able to operate with enough flexibility to accommodate the innovative approaches and relation-building that needs to continue throughout the life of the project.

5. **How do you know this maternal and child health initiative has been *successful*?**

   The initial predictors of success are increased cooperation between participating agencies, increased number of prenatal visits within the county, increased awareness of child advocacy issues in this year's local and state elections, and consistent media coverage of the county's progress surrounding the implementation of the project.

6. **Do you think that this *initiative* would work if implemented in *another urban community*?** We think this process is replicable. **Why?** Involving the community from the very start of the planning process is key. Being open to new ideas and welcoming change is also very important to establishing community buy-in.

1992 Urban Maternal and Child Health Leadership Conference

Health Department: City of Hartford Health Dept
Contact Person: Diana L Phillips
City/State: Hartford, CT
Telephone: (203) 722-6774

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Low birth weight; infant mortality; access to health care.

2. **Describe the *major accomplishments* of this initiative.**

   Expanded outreach efforts to enroll one-third of childbearing women.

   Designed and implemented a specialized outreach and prenatal screening for women living in shelters, projects, motels, and drug rehabilitation centers, to ensure that the expanded services reached women not receiving prenatal care.

3. **How is it funded?** City/County/Local government funds, General state funds, Hartford Foundation for Public Giving, Third party reimbursement (Medicaid, insurance).

   What is the approximate total annual budget for this initiative? $280,000.00

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**

Barrier 1: Access to care.	**How overcome?** Prenatal care administered at the shelter and transportation provided to the clinic for subsequent visits.
Barrier 2: Financial.	**How overcome?** Billing department is accessed after prenatal care has begun.
Barrier 3: Fear of the system.	**How overcome?** Utilization of the outreach staff on site with the nurse; and at the clinic site to help navigate the system.

5. **How do you know this maternal and child health initiative has been *successful*?**

   Evaluation in progress.

6. **Do you think that this *initiative* would work if implemented in *another urban community*?** Yes **Why?** Health professionals must begin to work with community groups and women's groups to plan for the education, support and delivery of services to childbearing families.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	Marion County Health Department	City/State:	Indianapolis, IN
Contact Person:	Jeff Lamore	Telephone:	(317) 541-3164

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   This program addresses lead toxicity in the very low income population in Indianapolis.

2. **Describe the *major accomplishments* of this initiative.**

   The Bureau of Environmental Health of the Marion County Health Department reached an agreement with the Center Township Trustee's Office that they (the bureau) would receive a referral copy of all applicants for assistance from the Trustee's Office. Center Township comprises the inner-city area of Indianapolis where large areas of run down homes are located. The Bureau then sends an Environmental inspector to the home to do a survey. If there are children in the home a phlebotomist is sent to draw a lead screen on them. The inspector also canvasses the other homes in the immediate vicinity for possible lead problems. The phlebotomist draws samples in these other homes where indicated.

   Prior to the implementation of this program door to door screening was producing a high lead incidence of 3-5%. The percent of high leads through this referral program is running between 20-30.

   This program also produces frequent referrals to C.P.S. and other social service agencies as multiple risk factors often exist in these homes. It has been a much more efficient method of case finding children with lead toxicity.

3. **How is it funded?** City/County/Local government funds, Other federal funds, Third party reimbursement(Medicaid, insurance).

   What is the approximate total annual budget for this initiative? $337,000.00

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**

Barrier 1: Finding people at home.	**How overcome?** This continues to be a problem.

Barrier 2: Cooperation from the clients.	**How overcome?** The lead surveyors and the phlebotomist are hired from the target communities. This has made a substantial difference.
Barrier 3: Funding as a result of operating the Atomic Absorption Spectrometer.	**How overcome?** We have just started billing Medicaid for the testing and are hopeful that they will agree to pay for the cost of inspections as well.

5. How do you know this maternal and child health initiative has been *successful*?

The increased percent of high leads discovered through this program is a much more efficient use of human resources than our former door to door program because it allows us to focus on persons living in the high risk areas of the City.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** I believe many communities have large pockets of old houses occupied by very low income people living in multiple high risk situations.

1992 Urban Maternal and Child Health Leadership Conference

Health Department: Mississippi State Dept of Health City/State: Jackson, MS
Contact Person: Hazel Gaines Telephone: (601) 960-7464

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Prenatal Care/Transportation /Child Care.

2. **Describe the *major accomplishments* of this initiative.**

   " HOLD OUT THE LIFE-LINE"
   Telephone Granny Program-calls the day before the appointment as a reminder.

   Transportation - church bus picks up prenatal patients for clinic appointment.

   Child Care - nursery during prenatal clinic hours to care for children - staffed by volunteers.

3. **How is it funded?** Churches, Community Groups

   What is the approximate total annual budget for this initiative?

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**

Barrier 1: Space for the nursery.	**How overcome?** Renovated a storage room and one of the community groups furnished it.
Barrier 2:	**How overcome?**
Barrier 3:	**How overcome?**

5. **How do you know this maternal and child health initiative has been *successful*?**

   Increased show rate for prenatal appointments.

6. **Do you think that this *initiative* would work if implemented in *another urban community*?** Yes **Why?** If could get churches, volunteer and community groups to sponsor. It did not require any financial support from the agency.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	Duval County Public Health Div	City/State:	Jacksonville, FL
Contact Person:	Donald Hagel MD Delores M Unsicker	Telephone:	(904) 630-3207

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   This initiative addresses: 1) access to health care, and 2) infant mortality and poverty.

2. **Describe the *major accomplishments* of this initiative.**

   The Wellness Van serves as a neighborhood outreach project to socio-economically disadvantaged clients who may have or perceive to have limited access to child health screenings, education and immunizations. Operations began in November, 1990 through a grant from City Housing and Urban Development (HUD) Community Block Grant. Since that time major accomplishments include (Impact/Outcome statistics will be gathered for long term gains in 93/94.): a) 12,939 childhood immunizations given 11/90-6/92; b) 26 Headstart blood pressure screenings; c) 851 EPSDT - Medicaid Screenings; d) 250 Lead Screenings for HUD; e) 46 Healthy Beginnings Classes held until funds for health education cut; f) Co-sponsor of special events and campaigns to increase awareness of child health needs. (Co-sponsors: Junior League, Local Pic N'Save stores); g) Distribution of literature for outreach and encouragement of early prenatal care, use of public health services.

3. **How is it funded?** City/County/Local government funds, Other Federal funds, Third party (Medicaid, insurance)

   What is the approximate total annual budget for this initiative? $150,000.00

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**

Barrier 1: Compliance and fragmentation of services (Continuity of care).	**How overcome?** The mission was clearly emphasized - it is not a source of replacement of regular primary care. Clients are referred from clinics for immunizations and routine screenings. The van staff refers clients to home clinic for sick and follow-up care. All van services are computerized and plans are in process to link records with the local clinics. Usage of the van has been steady due to consistency of the schedule to neighborhood housing areas.
Barrier 2: Scheduling of services. Schedules have to be planned and advertised well in advance. Also some areas may need special services due to need i.e.: limited transportation areas or areas of outbreaks such as measles.	**How overcome?** A program manager was placed to make contact with all housing/ tenant offices, all management and community agencies. A Van Advisory Committee also was selected and meets monthly to consider service needs and coordination.
Barrier 3: Vehicle procurement, maintenance and operation.	**How overcome?** Attainment of grant funds to refurbish old (1972) mobile clinics and special appropriation from city council for operations. Arrangements were also made with the City Motor Pool to maintain vehicle. Special training for staff in vehicle operation and efficient flow of service delivery. An "Opening" and "Closing" checklist was developed.

5. **How do you know this maternal and child health initiative has been *successful*?**

   The success of the wellness van initiative can be measured by its acceptance by the community in need of services. It provides an average of 25% of the childhood immunizations given by the public health unit each month. It's visibility and attention to the local residents draws media attention as well as providing awareness of the public health services and needs. Due to it's success in providing immunizations, lead screenings, two additional vans have been funded for use in the city/county. A Healthy Start van will provide prenatal and parenting education within local neighborhoods and a van purchased through Childrens Miracle Network Telethon funds will concentrate solely on immunization.

6. **Do you think that this *initiative* would work if implemented in *another urban community*?** Yes **Why?** It can be an extremely valuable public health service delivery mechanism as services can be directly taken to an area of need. During a measles outbreak, the van was able to concentrate in a designated target area. It can bring both services and education to an area and make use of local volunteers and business sponsors.

1992 Urban Maternal and Child Health Leadership Conference

Health Department: Kansas City, MO Health Dept
Contact Person: Cheryl Lee MA
City/State: Kansas City, MO
Telephone: (816) 923-2600

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   The project is an annual data book of maternal and child health indicators specifically for Kansas City.

2. **Describe the *major accomplishments* of this initiative.**

   Kansas City encompasses parts of three counties. MCH data provided by the State is presented only by county.

   Kansas City, as a major urban area, was without city-specific MCH indicators. Using State data tapes from vital records, city-specific data was obtained, analyzed, organized and published.

   This book, now in its tenth year, is available to local agencies and it extensively used in grant writing, long-range planning, project management and as a teaching tool in area nursing schools.

   By using vital record documents, the data are reliable and viewed as a benchmark for statistical analysis in the community.

3. **How is it funded?** City/County/Local government funds, MCH block grant funds

   What is the approximate total annual budget for this initiative? $4,500.00

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**

Barrier 1: Lack of appropriate computer hardware and software to store, analyze and display data.	**How overcome?** Equipment up-grade enabled through use of State MCH Block grant funds and city funds.
Barrier 2: Effective use of State data tapes.	**How overcome?** More contact with State to become familiar with State DP and vital records systems.

Barrier 3: Cost to print books.	**How overcome?** Reallocation of some MCH Block grant funds to cover cost of printing, in conjunction with additional city funding.

5. How do you know this maternal and child health initiative has been *successful*?

Positive feedback from area health providers; continuous input from users suggesting improvements; increasing demand for the publication.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** If a trained statistician is available to manage the project, if the data source is cooperative (usually the State). If appropriate hardware/software is available, and if feedback is actively requested from the potential audience.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	Lexington-Fayette County Health Department	City/State:	Lexington, KY
Contact Person:	Regina Moore RN	Telephone:	(606) 288-2431

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   All of the above.

2. **Describe the *major accomplishments* of this initiative.**

   All women with positive pregnancy tests done at the Health Department are counseled regarding the need for early prenatal care and possible resources according to the woman's needs. Uninsured women and women with medicaid gain entry into the system either through contacting the Center or the University of Kentucky Medical Center. Each patient who presents for care is assigned a nurse case manager. At the preliminary visit, risk assessments utilizing the state MCH, are completed. The patient receives WIC services, financial screening to determine Medicaid eligibility if appropriate, and an appointment is made for medical care. The patient's medical care is arranged with a local obstetrician with whom the Center contracts, or the University of Kentucky Medical Center obstetrical staff. A referral is made for the home visiting department, and appropriate physical care education is provided.

   The case manager coordinates all referrals and monitors the care that is given, follows-up to assure that the patient made and kept appointments, assures the receipt of diagnostics and appropriate interventions, education nutrition counseling, infant care planning, and delivery systems. Home visits are made routinely at least once during the prenatal and post-partum periods, and as needed according to the patient's needs. The home visit includes assessment of the home, and prenatal health care, and of support systems. Teaching specific to the patient's needs and gestation is provided by the program's clinic nurses, and reinforced and elaborated on by the home visiting nurse during the home visit. In addition, services are provided during clinic visits, individual counseling sessions, and group education sessions.

3. **How is it funded?**

   What is the approximate total annual budget for this initiative?

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**	
Barrier 1: Obstetricians in Fayette County do not routinely accept Medicaid patients.	**How overcome?** Uninsured women and women with Medicaid gain entry into the system either through contacting the Center or the University of Kentucky Medical Center. From that entry point, they are assigned a nurse case manager, and either a local obstetrician with whom the Center contracts, or the University of Kentucky Medical Center obstetrical staff who provide the medical component of care.
Barrier 2:	**How overcome?**
Barrier 3:	**How overcome?**

5. How do you know this maternal and child health initiative has been *successful*?

The number of Medicaid and uninsured women enrolled in the prenatal program has almost doubled this year, compared to the number of women enrolled last year. Of these women, 43% entered prenatal care in the first trimester and 11% entered care during the third trimester. The first trimester entry is about the same and the third trimester entry has improved by 1.8% this year.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** This initiative would work in other urban communities if the local health departments collaborate with program staff within their agency, as well as community providers such as hospitals, obstetricians, local and state governments, and maternal and child health care advocates, in order to obtain funding, facilities, and multidisciplinary staff to provide services.

1992 Urban Maternal and Child Health Leadership Conference

Health Department: Arkansas State Dept of Health City/State: Little Rock, AR
Contact Person: Aurian Zoldessy RN Telephone: (501) 663-6080

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Infant Mortality, failure to thrive, access to care in limited cases.

2. **Describe the *major accomplishments* of this initiative.**

   Developed a rapport with area hospitals and interested physicians regarding newborns and infants needing closer home monitoring and case management.

   Though limited funding prevented offering services to all infants in the county who could qualify for these services, many cases were documented where infants lives were saved and harm prevented because a nurse, social worker, or aide was in the home to intervene or guide a care giver through critical care giving situations.

3. **How is it funded?** General state funds, MCH block grant funds, Other Federal funds

   What is the approximate total annual budget for this initiative? $102,474.00

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**

Barrier 1: Lack of funding to support adequate staff to provide services to entire county.	**How overcome?** We reduced the size of the geographical area served in order to limit the caseload.
Barrier 2: Difficult to recruit nursing staff for this activity.	**How overcome?** Much of the intervention needed was for non-professional skills, i.e.: someone to help mother get through the Social Services system, to support families in maintaining a clean healthy environment, to teach basic nutrition. We converted a Nursing position to a Social Service Worker who could be more available to families for such needs.

Barrier 3:	How overcome?

5. How do you know this maternal and child health initiative has been *successful*?

Statistics have not yet been compiled. Assessment may be difficult due to the small caseload. (Two RN's, one Social Worker, and one Aide carry a caseload of about 150 families.) However, many anecdotal records exist attesting to individual successes.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** Basic needs of families are the same....for support, guidance and teaching.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	Memphis Shelby County Health Department	City/State:	Memphis, TN
Contact Person:	Brenda Kinney MSN RNC	Telephone:	(901) 576-7874

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Potential cognitive deficits. Lead screening to meet new CDC guidelines.

2. **Describe the *major accomplishments* of this initiative.**

   A smooth transition to testing for blood lead levels of 10 ug/dl and implementation of Federal Guidelines was achieved in June, 1992. This was related to a realistic expectation of the dimensions of the problem, based on a 2 month sampling of children (N=567) in a high volume clinic located in a densely populated area of the inner city.

   A request for funding State-Of-The-Art Lab. equipment was tentatively approved by a local funding source pending county budget decisions. The accuracy of capillary vs. venous blood levels was determined so that the protocol could be prepared and the predictability of a Center for Disease Control questionnaire was tested and found wanting. The Environmental Division was able to be better prepared to deal with the increased case load.

3. **How is it funded?** City/County/Local government funds

   What is the approximate total annual budget for this initiative? Part of general budget.

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**

Barrier 1: The increased costs if it was necessary to collect venous blood for each sample (time, effort and money).	**How overcome?** A comparison of capillary vs. venous blood samples indicated that capillary blood tested if anything, at higher levels than venous blood making it ok for the first level of screening.

2 **Barrier 2:** As the FEP was no longer valid, laboratory time and manpower needs were increased to the point of monopolizing the central lab. Cut-backs in county funding jeopardized the potential purchase of equipment.	**How overcome?** A grant application to purchase a Graphite Furnace Atomic Absorption Spectrophotometer was approved pending county budget decisions (the budget item was approved so grant funds were not needed).
Barrier 3: During the study period, the sample questionnaire from the CDC was found to show no relationship between answers given and blood lead results for this population.	**How overcome?** A new lead screening questionnaire has been developed and is currently being piloted with: 1) children aged 3 who were recorded as class I at age 2 years of age, and 2) as part of the protocol for class II A and II B children.

5. How do you know this maternal and child health initiative has been *successful*?

1) We are picking up children with increased blood lead levels who had not had an FEP of 35 or above at previous screenings under the "old" protocol.

2) Although the system would be improved with increased manpower and funds, the system has not been overwhelmed.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** The overall principles would work but it demonstrates the need to test methodologies for each community.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	HRS Dade County Public Health Unit	City/State:	Miami, FL
Contact Person:	Eleni Sfakianaki MD	Telephone:	(305) 324-2401

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Lead poisoning in children.

2. **Describe the *major accomplishments* of this initiative.**

   A. Prevalence of lead poisoning in young children (aged 1-3 years) of low-income families in a large metropolitan are was determined.

   B. Identification of possible environmental sources of lead poisoning is in process.

   C. A plan of action for follow-up and/or necessary intervention is being developed.

3. **How is it funded?** Private sources: Small grant by a private foundation, Third party reimbursement (Medicaid, insurance)

   What is the approximate total annual budget for this initiative? $10,065.00

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**

Barrier 1: Lack of funding to cover the cost of the laboratory support needed for this project.	**How overcome?** A presentation was made to Dade County's Environmental Advisory Task Force thus creating awareness. A request was also made at the same time for financial support. The Task Force endorsed the request and a private foundation came forward and financed the project.
Barrier 2: Lack of local laboratory proficient in performing required test. Difficulties in coordinating collection and shipment of supplies.	**How overcome?** State laboratory in Jacksonville agreed to perform the tests. Staff was trained to properly collect, store and handle samples.

Barrier 3: Lack of automation in recording participation from various satellite clinics.	**How overcome?** Not very efficiently. Additional work and effort made by staff to manually record and track all participants, call for follow-up tests and coordination with environmental investigation.

5. How do you know this maternal and child health initiative has been *successful*?

The project was completed as intended. Data gathered are being used to further address the problem.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** This initiative brought together a major university, the local health department, local government and the private sector. It created community awareness and obtained private funding to address a childhood problem.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	City of Milwaukee Health Dept	City/State:	Milwaukee, WI
Contact Person:	Amy Murphy Manager, Lead Poisoning Program	Telephone:	(414) 286-8028/
	Elizabeth Zelazek Public Health Nursing Manager		(414) 278-3606

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Lead Poisoning.

2. **Describe the *major accomplishments* of this initiative.**

   Increased level of screening in the community with the majority of increase generated by private physicians. This has been accomplished through a physician education and outreach program conducted by a nurse "donated" to the Health Department by the local Children's Hospital.

   Passing of lead abatement ordinance by the City's Common Council, which sets minimum standards for abatement of lead in dwelling units, requires permits for contractors who must meet training requirements and strengthens the enforcement options of the City for violation of the ordinance.

   In anticipation of the revised CDC guidelines, department-wide planning with input from all levels of staff for outreach, intervention and education strategies and most notably, the role of Public Health Aides (paraprofessional outreach workers) who conduct prevention oriented home visits which include education, home inspection and demonstration of clean-up skills.

   Participation in research, specifically a "fingerstick" study conducted in cooperation with CDC, to study the effectiveness and accuracy of different methods of cleaning the fingerstick site.

   Strong community support and positive working relationships fostered specifically through the establishment of a Lead Task Force which brings together public and private sector representatives from the health, housing, education, legislative and legal arenas, as well as community representatives. This has led to prevention of service barriers and has generated increased funding.

3. **How is it funded?** City/County/Local government funds, General state funds, CDC, Private Foundation

   What is the approximate total annual budget for this initiative? $1,210,000.00

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**	
Barrier 1: Tracking and coordination of data. Integration of data between public health nursing, environmental, lab and community providers.	**How overcome?** Use of computerized lead database-STELLAR. Refinement and revision of the system over the last year, working closely with data specialist from CDC. Chosen by CDC as a demonstration site for refinement of the system. (STILL IN PROCESS)
Barrier 2: Integration of high profile, high intensity lead program into overall programming of the Health Department. Ability of public health nursing and environmental health to keep up with case management needs of increased case loads generated by increased screening.	**How overcome?** Formation of an internal Health Department work group consisting of managers and staff. Consideration of different models of service delivery and more efficient use of personnel, especially paraprofessionals. Frequent reconsideration of the type of intervention necessary (and possible) at different levels of lead classification. (STILL IN PROCESS)
Barrier 3: Expected and usual adversarial relationship between a lead program and landlords/owners.	**How overcome?** Involvement of both through inclusion in the Lead Task Force (advisory group). Specific involvement in the drafting of the lead ordinance. Health Dept support of abatement efforts through training, loaning specific equipment (HEPA vac) and procurement of private foundation money to assist with abatement.

5. **How do you know this maternal and child health initiative has been *successful*?**

Through the increased screening level, the involvement of the private medical community, the financial support of public and private dollars, the favorable press received and strong community involvement. Plans now being developed for standard program evaluation of medical and environmental pieces.

6. **Do you think that this *initiative* would work if implemented in *another urban community*?** Yes **Why?** But needs high level leadership and commitment in light of other pressing urban public problems. Lead initiatives have the national attention necessary to obtain focus and dollars. Most urban areas have requisite poor housing to demonstrate the problem.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	City of Minneapolis Health Department	City/State:	Minneapolis, MN
Contact Person:	Edward P Ehlinger	Telephone:	(612) 673-2780

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   (a) Lack of MCH and Public Health information available to the general community.

   (b) Lack of media skills among MCH and Public Health professionals.

   (c) Lack of visibility of MCH and Public Health professionals.

2. **Describe the *major accomplishments* of this initiative.**

   A bi-weekly cable television show entitled, "A Public Health Journal" was initiated in 1985 and has continued to the present. Over 150 half hour shows have been produced. In addition, 2 ninety-minute Socratic discussions on "Access to Care" and "For Profit Health Care" have been produced. The shows air weekly on 3 cable channels in Minneapolis and the Twin Cities Metropolitan area.

   The show uses an interview format hosted by Ed Ehlinger, Director of Personal Health Services of the Minneapolis Health Department. Staff from the Minneapolis and Hennepin County Health Departments have been trained to be camera operators and sound technicians. Guests on the show include MCH and Public Health experts from state and local health departments and community agencies.

   "A Public Health Journal" is sponsored by the Minneapolis Health Department, the Hennepin County Community Health Department and the Minnesota Public Health Association. Copies of programs are made available to schools, libraries, and other cable channels throughout Minnesota.

3. **How is it funded?** City/County/Local government funds

   What is the approximate total annual budget for this initiative? $17,000.00

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**	
Barrier 1: Lack of expertise in media production among staff of the health department.	**How overcome?** Staff participated in training programs on camera operation, television production, and on-camera skills.
Barrier 2: Concern that the program might generate some controversy.	**How overcome?** Programs has stuck to factual topics. As experience was gained with the program and its content, it became clear that the program would serve a health education function and not a political function.
Barrier 3:	**How overcome?**

5. How do you know this maternal and child health initiative has been *successful*?

(a) Comments, calls and letters have been received from viewers giving positive feedback about the programs' content and quality.

(b) Because of their experiences on "A Public Health Journal," guests have been more willing to appear on the commercial television stations.

(c) Staff have become better purchasers of video production services for other purposes.

(d) This department has become more video oriented.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** This is an effort that could be replicated in any community that has public access cable television. It requires an individual who is interested in using television as a tool for health education. Cable companies will supply the basic start-up information.

1992 Urban Maternal and Child Health Leadership Conference

Health Department: Mobile County Health Dept
Contact Person: Shirley Worthington MSW
City/State: Mobile, AL
Telephone: (205) 690-8852

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Access to care with ultimate goal to reduce infant mortality/morbidity.

2. **Describe the *major accomplishments* of this initiative.**

   Initiative: Medicaid Waiver Maternity Program

   Components:

   A. SOBRA Medicaid Outstation Workers (4) located at Mobile County Health Department.

   B. Implemtation of Case Management model of health care provision.
      1. Psycho-social assessment/individualized case plan for each maternity patient.
      2. Missed appointment follow-up.
      3. Implementation of routine HIV testing.
      4. Post-partum/pediatric appointments scheduled through hospital visit post-delivery.
      5. No Prenatal Care patients tracked for post-partum pediatric follow-up.

   C. Early discharge/family planning/EPSDT R.N. home visits.

3. **How is it funded?** MCH block grant funds; 330 funds

   What is the approximate total annual budget for this initiative? $1.5 million MCHD Waiver High.

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**	
Barrier 1: Limited provider available. MCHD Waiver High Risk clinic site.	**How overcome?** Contract with USA Medical School resident services. Coordination with Medical School for alternate clinical/delivery schedules for residents to facilitate scheduling. Explore expansion of CRNP for routine maternity care.
Barrier 2: Block scheduling/patient waiting time. Space limitations.	**How overcome ?** Revised scheduling to individualized appointment system. Re-located patient registration and lab within clinic to facilitate patient flow. Purchased satellite location for maternity/family planning/patient education/WIC programs.
Barrier 3:	**How overcome?** Medicaid

5. How do you know this maternal and child health initiative has been *successful*?

Medicaid eligible patients rose from 25% pre-SOBRA to 90% in 1991. First trimester enrollment rose from 52% to 63% in one year. Second trimester reduced from 34% to 30% and third trimester reduced from 14% to 7%. Home visit early discharge completion rate 90%. Family planning home visit completion rate 78%. Postpartum compliance rose from 63% to 70%. Infant mortality showed significant reduction in Black infant mortality from 15.8/1,000 to 13.5/1,000.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** Case management/community networking concept enhances patient access, compliance, coordination of services effectively, utilizing pre-existing program coordinated through a health care waiver containment system.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	New Orleans Health Department	City/State:	New Orleans, LA
Contact Person:	Susanne T White MD MPH	Telephone:	(504) 565-6907

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Great Expectation is an initiative to decrease the infant mortality rate in the city of New Orleans.

2. **Describe the *major accomplishments* of this initiative.**

   At the same time it is to improve access to health care and begin to improve the poverty rate by employing persons from target neighborhoods. Great Expectations seeks to improve infant mortality by collaborating with Department of Obstetrics and Gynecology at LSU to provide community services. This will provide easy access to health care. A more unique initiative is to use "Nanans and Parrains" as outreach workers in the community, who will provide education and screening of the at risk population. This is neighborhood based. The nanans with parrains will be trained through a newly designed course at Delgado Community College and college credit hours toward a B.S. degree can be possible. With the education of these Nanans/ Parrains, they are empowered to go into their neighborhoods to screen and educate others and refer into the prenatal or pediatric clinic. The pediatric component included identification and close follow-up of all children in the target area. During this time well baby care, immunizations, anticipatory guidance and developmental screening will take place. The nanans and parrains will be available to continue postpartum counseling to ensure parents are capable of caring for their infants.

3. **How is it funded?** City/County/Local government funds, MCH block grant funds, 330 Funds, Other Federal funds.

   What is the approximate total annual budget for this initiative?

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**

Barrier 1: Civil Service Salary Restrictions.	**How overcome?** Private consulting agency was employed to perform a study on Civil Service Salaries. A proposal to change the classification of employees with salary increases has been submitted. Another recommendation is negotiation and sharing physicians through contracts with existing two medical school facilities. These physicians/nurse practitioners would broaden and expand the medical staff of the Health Department.
Barrier 2: Fragmentation of Care.	**How overcome?** The City is attacking this problem from various angles through the Mayor's coalition on Primary Health Care, and the Great Expectation Consortium. Integration of Public Health with Medical Schools and the Medical Center of Louisiana and the Community Health Centers will improve the quality of health care allow a pool of resources and decrease duplication of services.
Barrier 3: Lack of space to provide services.	**How overcome?** Two proposals were submitted to the State Capitol budget and were funded. Another proposal will be submitted for the possibility of expanding space in all the Maternal & Child Health Units. Negotiations for other funding resources consist of the Community Development Black Grant Project, as well as appeal to the community and negotiations with City Councilman/women for additional revenues from the City.

5. **How do you know this maternal and child health initiative has been *successful*?**

   This project can be listed as successful in being able to get health care agencies throughout the city to begin to negotiate and share in the care of expectant mothers and children. The initiative itself is just beginning with the employing of the Nanans and Parrains. If you justify the overwhelming response for application to train these case managers as an early success, it can be said to be successful. Evaluation of the entire project will take 1-3 years, before data is available to the answer.

6. **Do you think that this *initiative* would work if implemented in *another urban community*?** Yes **Why?** This initiative will work in other areas with a well thought out plan and collaboration between agencies.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	Department of Health & Human Services	City/State:	Newark, NJ
Contact Person:	Claude L Wallace	Telephone:	(201) 733-7590

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Access to health care: Lack of age appropriate immunization.

2. **Describe the *major accomplishments* of this initiative.**

   In response to a State declared measles emergency, the City of Newark embarked on a short term educational campaign to impact on the spread of measles. The Newark Health Department through a grant funded by the New Jersey Department of Health developed posters, flyers, radio campaign centered around the Ninja Turtles. A publicity session was held at the Newark City Hall with the creator of the Ninja Turtles (Marc Freedman) and Michelangelo.

   The initiative generated much parental interest in that telephone calls began pouring in requesting measles information, and parents were bringing children and their immunization records for review.

   An "Immunization" stand was set-up in one local department store to administer vaccine as requested, to supply education and information and to network with shoppers to request their assistance in informing friends and relatives about the measles emergency.

   Inducements such as balloons, photographs and tee shirts were distributed during various phases of the campaign to encourage participation.

3. **How is it funded?** General state funds.

   What is the approximate total annual budget for this initiative? $25,000.00

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**

Barrier 1: Cost.	**How overcome?** Grant from the State.

Barrier 2: Lack of participation of children not connected to outside agencies such as pre-school, day care, etc.	**How overcome?** Door to door distribution of information.
Barrier 3:	**How overcome?**

5. How do you know this maternal and child health initiative has been *successful*?

The success of the program was measured in terms of an increased response which was not evident or detectable prior to the campaign.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** The strategy is feasible in that it is relatively straight forward in nature. However, it is very costly and should be sustained on a long term basis in order to have more significant impact.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	New York City Dept of Health Bureau of Child Health	City/State:	New York, NY
Contact Person:	Dr Carmen Ramos	Telephone:	(212) 788-4972

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Under identification of children with asthma who are already enrolled at the Bureau of Child Health's clinics, and providing them with access to preventive treatment.

2. **Describe the *major accomplishments* of this initiative.**

   This initiative is part of a 5 Year collaborative pilot project between the NYC Department of Health's Bureau of Child Health, and the Pediatric Pulmonary Division of Columbia University College of Physician and Surgeons. Beginning in August 1990, year one involved the joint planning of the implementation of this pilot. In year two, all staff members, medical and auxiliary, in 11 selected clinics were trained:

   a) to be aware of symptoms of asthma, and how they impact on the lives of children and families of children who have asthma,
   b) that the best way to treat asthma is to prevent attacks rather than simply relying on treatment after it has started,
   c) that asthma is easier to manage if families and health care providers work together as a team,
   d) how to screen registered clients for asthma,
   e) how to provide preventive asthma care for children already registered in BCH clinics,
   f) how to treat asthma with inhaled medications,
   g) how to teach families how to administer inhaled medications,
   h) how to empower families to manage asthma in such a way as to allow children to live a normal life, without excessive absences from school of restrictions from physical activities due to asthma.

   Now in year three, the eleven "Medical Homes for Children with Asthma" are in operation. The effectiveness of the pilot's intervention will be evaluated during this year. Planning is underway for training the Child Health Supervisors to implement this program in the remaining clinics, in order to make this program self-sustaining.

3. **How is it funded?** Other Federal funds

   What is the approximate total annual budget for this initiative? $2,650,935.00

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**	
Barrier 1: Staff fears that implementing this program would result in an overflow of walk-in clients using the clinic as an emergency room when children have asthma attacks.	**How overcome?** Staff education about the purpose of the program being "Preventive Care" and problem solving techniques for dealing with scheduling, communication and management issues.
Barrier 2: Discomfort of staff in implementing the new clinical protocols.	**How overcome?** Staff have the opportunity to consult regularly with the Columbia team physicians, Dr. Robert Mellins and Dr. Lynn Quittell. Child Health clinicians also attended individual sessions to observe Drs. Mellins and Quittell use the recommended protocols with their respective patients.
Barrier 3:	**How overcome?**

5. How do you know this maternal and child health initiative has been *successful*?

The effectiveness of the pilot intervention is being formally evaluated this year. However, a 3 month period from March to May, 1992 saw 4,928 children screened in these 11 clinics. 533 were found to have Asthma, and were offered the opportunity of receiving preventive care at the BCH clinic.

6. Do you think that this *initiative* would work if implemented in *another urban community*?

Why? Should this project prove successful, the program is especially designed to be effective in other metropolitan areas with large minority or disadvantaged populations.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	Norfolk Dept Public Health	City/State:	Norfolk, VA
Contact Person:	Joyce L Bollard	Telephone:	(804) 683-2780

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Multi-need children and families, poverty, adolescent pregnancy, school drop outs, emotionally disturbed, child abuse, delinquency, and substance abuse.

2. **Describe the *major accomplishments* of this initiative.**

   - The Norfolk Youth Network is made up of six agencies: Community Services Board, Division of Social Services, Juvenile Court Services, Juvenile Services Bureau, Public Schools and Public Health. The Network was created to coordinate community resources and to maximize the effectiveness of treatment, intervention for multi-need children and families. Intensive coordinated community-based treatment efforts provide a comprehensive system of care. The Network has two levels: The Norfolk Interagency Consortium (NIC), the Administrative Level, and eight (8) Community Assessment Teams or (CATS), the Service Delivery Level.

   - The NIC successfully obtained a demonstration grant from the state for approximately $1,000,000 to make community-based services possible: Preventive Home-based Services; Therapeutic Family Homes; Intensive Probation Services; Transitional Home-based Services; Therapeutic Respite Care and Pre-School Prevention Program.

   - The CATS have reviewed and staffed a total of 558 cases from 7/91 to 3/92; 139 of those were new cases and 419 cases were for follow-up and reviews. The CATS created long term plans of care and monitored and followed-up all recommendation on each of these cases.

3. **How is it funded?** City/County/Local government funds; General state funds; Third party reimbursement (Medicaid, insurance)

   What is the approximate total annual budget for this initiative? $1,000,000.00

4. What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?

Barrier 1: Turf issues.	**How overcome?** Support from highest administrators and real commitment on the part of each agency as well as sincere desire of individuals involved to make inter-agency collaboration work. Many sessions of deliberation and education of each of the participants regarding the other agencies' rules, regulations, policies, etc. were necessary.
Barrier 2: Training.	**How overcome?** Quarterly meetings of the entire Network (NIC and CATS) for interagency training, designed to re-inforce interagency and team concept. These served to give the Network an identity. Participants developed pride in being part of such an exciting and challenging venture.
Barrier 3: Coordination.	**How overcome?** Development by the Network of a successful grant application to fund a coordinator's position.

5. How do you know this maternal and child health initiative has been *successful*?

This initiative has reduced the cost of residential care for our youth with a 50% reduction in state psychiatric facilities' placements and reduction in Social Services placements from 41 residential placements in 7/90 with a cost of $192,000/month to ten (10) residential placements in 3/92 at a cost of $45,000/month. It has enabled some families to stay together and has kept children in their own community. This effort has increased interagency collaboration in other areas of concern in our city as well.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** When agencies work together, duplication of services and fragmentation of care are avoided. There is a reduction in cost and emphasis on maintaining the child and family in their own community. Any one of these improvements would be reason enough.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	Alemeda County Health Care Services Agency	City/State:	Oakland, CA
Contact Person:	Barbara Allen MD	Telephone:	(510) 268-2628

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Infant morbidity/mortality secondary to congenital syphilis.

2. **Describe the *major accomplishments* of this initiative.**

   The syphilis screen mobile van expanded its scope of services to include a comprehensive physical exam, HIV testing and counseling and referral/follow-up for abnormal exam findings and lab tests.

3. **How is it funded?** MCH block grant funds; Other Federal funds;

   What is the approximate total annual budget for this initiative? $100,000.00

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**

Barrier 1: Maintaining a collaborative relationship with State (STD unit), Federal (Title X), and Community-based Organizations.	**How overcome?** Continued to staff coordination meetings and modify respective roles and responsibilities for each collaborator.
Barrier 2: Hard to reach population -- distrustful of traditional health care institutions; crisis oriented.	**How overcome?** 1) Used outreach workers from the community - reformed prostitutes and drug users. 2) Offered financial incentives to high risk women attending the "outing" and returning for results.
Barrier 3:	**How overcome?**

5. How do you know this maternal and child health initiative has been *successful*?

1) High rates of seroprevalence in women examined.
2) Lack of health care for this hard to reach population.
3) High rates of follow-up visits for results.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** Many other urban communities have witnessed an increase in STD cases as a result of the drug epidemic.

1992 Urban Maternal and Child Health Leadership Conference

Health Department: Douglas County Health Dept
Contact Person: Betty Allen RN MPH
City/State: Omaha, NE
Telephone: (402) 444-7395

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Poverty, access to health care, violence in the form of child abuse and neglect, ignorance regarding care of the young child.

2. **Describe the *major accomplishments* of this initiative.**

   Day Care Nursing Program:

   Every preschool child is entitled to a level of social, emotional and physical health that will allow the child to develop to his/her maximum potential. The preschooler's health status can be compromised by risk factors found in the home, community and child care environments.

   By providing nursing services to Title XX funded day care center administrators, staff and children, the Douglas County Day Care Nursing Program increases the ability of the preschooler to develop to his/her maximum potential.

   The nursing services provided in each Title XX funded center served include:
   1. Growth and developmental screening, referral and follow-up for attendees.
   2. Initiation of health maintenance and immunization record keeping for attendees.
   3. Communicable disease control and sick child assessment.
   4. Health teaching and promotion of health care for children, day care staff, and parents.
   5. Consultation in all health-related and child development completion of areas.
   6. Health information reports and health maintenance for staff.
   7. In-service education programs with continuing education credits for day care staff.

3. **How is it funded?** City/County/Local government funds; General State funds.

   What is the approximate total annual budget for this initiative? $113,000.00

4. What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?	
Barrier 1: Day Care Center Cooperation - Sensitive issues (such as child abuse reporting) find operators, at times, reluctant to cooperate and become involved with situations discovered by the nurse.	**How overcome?** Provision of in-service education regarding important day care health issues (child abuse, immunization, communicable disease reporting) enlighten Day Care Center operators and staff and demonstrate the value of nursing services.
Barrier 2: Funding - Limited funding does not allow for service provision to all Day Care Centers.	**How overcome?** Grants have been applied for to supplement the local tax dollars provided for this program.
Barrier 3:	**How overcome?**

5. How do you know this maternal and child health initiative has been *successful*?

a. Anecdotal information through observation i.e. increased handwashing by staff and attendees, improved diapering techniques, increases in requests for in-service education.
b. Evaluation of program by Day Care Operator - annual evaluation provides input as to successes, program areas needing modifications, new areas of concern. Overall, evaluation shows program is well accepted.
c. Existence of waiting list to enter program. Due to budget limitations not all Day Care Centers can be served. A waiting list of Day Care Centers requesting services exists demonstrating popularity of the program.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** Problems found in Day Care Centers in Omaha are similar to problems found throughout the nation. Postured in an appropriate fashion, the offer of day care center nursing services would be a widely accepted program.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	Philadelphia Department of Public Health	City/State:	Philadelphia, PA
Contact Person:	Marjorie Scharf Nutritionist	Telephone:	(215) 875-5954

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Low birth weight, nutrition.

2. **Describe the *major accomplishments* of this initiative.**

   The Healthy Foods, Healthy Baby series published by the Office of Maternal and Infant Health, Philadelphia Department of Public Health, provides a set of innovative, literacy appropriate material for young African-American and Latino women, ages 15 to 25, who are pregnant. The series is designed to engage young women in healthy eating and healthy weight gain during pregnancy. The series is available in both English and Spanish.

   All of the Healthy Foods, Healthy Baby material were designed with the extensive involvement of pregnant and parenting young women throughout Philadelphia. These materials provide community teachers and health professionals with strong underlying and attractive aids to use in their teaching. The Health Department makes these materials available at no cost to facilities in Philadelphia. The Department also provides regular training in use of materials. These materials can supplement the professional expertise of a trained nutritionist or they can form the basis of the teaching done by a community health worker or nurse.

3. **How is it funded?** City/County/Local government funds; SPRANS funds; March of Dimes.

   What is the approximate total annual budget for this initiative? $40,000.00 (F 92) and staff.

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**	
Barrier 1: Implementing materials in a setting when you have no supervisory/oversight relationship.	**How overcome?** The development phase of this project involved many staff who are in the position to use the materials. Staff feel ownership of project. Staff are given opportunities to make suggestions to improve the materials - suggestions are incorporated into the future revisions. Staff feel they are heard.
Barrier 2: Staff shortage - Only one public health nutritionist to develop, promote use of guidebook.	**How overcome?** Trainings, quarterly meetings with prenatal nutritionist and health educators, mailings and presentations all help to promote the use of materials in a manner which is not staff intensive.
Barrier 3:	**How overcome?**

5. How do you know this maternal and child health initiative has been *successful*?

It has been reprinted four times, including reprints by USDA and DHHS for national dissemination. Approximately 300,000 copies are in circulation throughout the United States and Canada. All prenatal sites in Philadelphia use the pamphlet.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** Other urban communities are already using the materials. The training component and implementation process can be replicated to develop other health educational materials and would result in products tailored to urban communities.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	Maricopa County Department of Public Health	City/State:	Phoenix, AZ
Contact Person:	LoAnn Bell RN	Telephone:	(602) 506-6767

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Infant immunizations.

2. **Describe the *major accomplishments* of this initiative.**

   Establish a series (n = 6) of community-based evening (3-7 p.m.) immunization clinics. Institute a reminder system in conjunction with clinics and provide for an "express" lane for infants returning with reminder cards. This initiative was started 18 months ago. We have seen steady usage of the clinics by the public and a steady gradual increase in the number of infants that are being immunized. We are expanding the concept to smaller neighborhoods using a mobile clinic.

3. **How is it funded?** City/County/Local government funds; Volunteer assistance from local Kiwanis.

   What is the approximate total annual budget for this initiative? $120,000.00 + vaccine.

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**

Barrier 1: Identifying community sites that could accommodate large crowds of people (200-500 possible at one time).	**How overcome?** Relied on CHN knowledge of district and referrals from community leaders.
Barrier 2: Flexing work hours for nursing.	**How overcome?** Easy - This concept arose from CHN's.
Barrier 3:	**How overcome?**

5. How do you know this maternal and child health initiative has been *successful*?

Our goal is 90% kids immunized prior to 24 months of age. We are monitoring the # of children with completed series and the percentage of infants seen at each program.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** It is relatively simple.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	Allegheny County Health Dept	City/State:	Pittsburgh, PA
Contact Person:	Virginia Bownam	Telephone:	(412) 355-5949

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Infant and maternal morbidity, low maternal self-esteem, poverty, low childhood immunization rates, low breast-feeding initiation and duration rates, poor mothering skills/education.

2. **Describe the *major accomplishments* of this initiative.**

   The Department's Breast-feeding Promotion Program has several components which promote and encourage breast-feeding. The Allegheny County Breast-feeding Promotion Steering Committee (ACBPSC) promotes breast-feeding through collaborative efforts of diverse health and community professionals representing various health care centers, hospitals and local groups. The members work in subcommittees to carry out their respective goals. Current projects include a December 1992 breast-feeding conference, planning a Breast-feeding Helpline, and encourage area hospitals to become "Baby-Friendly" as described by the WHO/Unicef guidelines.

   The MMOM Program, a breast-feeding peer counselor program, works with WIC clients who have decided to breast-feed or are undecided regarding their infant feeding choice. The peer counselors, called doulas, from the Greek meaning "mothering the mother", were or are WIC clients themselves who have had a prior comfortable breast-feeding experience. The doulas provide telephone consultation and in-home visitation to clients in their own neighborhoods. A doula interacts with each client until she makes an informed decision to discontinue breast-feeding. A doula reports to and consults with an International Board Certified Lactation Consultant on staff. A doula encourages clients to seek appropriate health care and makes necessary referrals for mother and baby. Childhood immunizations are encouraged by every doula to every client.

   If a client delivers a premature baby or experiences a breast-feeding problem that necessitates an electric breastpump, one is available free of charge. This further prolongs, and makes comfortable, the breast-feeding experience for the client.

   Certified lactation consultants provide professional breast-feeding consultation via telephone for WIC clients living in areas not served by a doula or who prefer telephone support.

3. How is it funded? MCH block grant funds; Other Federal funds;

What is the approximate total annual budget for this initiative? $175,000.00

4. What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?

Barrier 1: Implementing a new initiative within a bureaucratic system, particularly obtaining release of funds.	**How overcome?** Patience, perseverance and knowledge of bureaucracy.
Barrier 2: Developing doula training manual and MMOM Program records.	**How overcome?** Revisions, revisions, revisions: Cooperation from clerical staff, technical assistance from health educator for literacy level design and artwork from another administrator.
Barrier 3: Recording and accountability requirements imposed on paraprofessionals who lack experience and education.	**How overcome?** Flexibility on the part of everyone involved in implementing program. This flexibility was stressed as a necessity to the doulas prior to hiring and continues to be practiced in arranging the program.

5. How do you know this maternal and child health initiative has been *successful*?

Many hospitals in Allegheny County now have lactation consultants on staff. Hospital continue to show enthusiastic support. Referrals to MMOM Program continue to escalate. The second class of doulas graduated this past summer, 1992. There is a high demand for the MMOM Program in areas currently not serviced by a doula. A common response of clients is "I wish you were here for the first time I tried to breast-feed." The doulas themselves report job satisfaction and feelings of positive self-esteem.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** Much incorrect advice and misconceptions exist about breast-feeding. A steering committee helps to promote and educate about breast-feeding generally. The MMOM Program helps to educate those at greatest need - low income mothers/families.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	City of Portland Public Health Division	City/State:	Portland, ME
Contact Person:	Lisa Belanger	Telephone:	(207) 874-8300 ext. 8784

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Childhood Lead Poisoning Initiative.

2. **Describe the *major accomplishments* of this initiative.**

   - Successfully passed an aggressive bill to prevent childhood lead in Maine.
   - Developed and sustained a statewide coalition of concerned individuals who organized legislators and advocates around the legislation and public education by sponsoring a statewide educational forum.
   - Participated in the development of a successful grant proposal to the Centers For Disease Control to bring childhood lead poisoning prevention monies to both the state and our health departments.

3. **How is it funded?** City/County/Local government funds; Benevolent Association

   What is the approximate total annual budget for this initiative? $10,500.00

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**

Barrier 1: Lack of data to support the need for resources legislation.	**How overcome?** Develop a local data gathering system. Did a retrospective study and developed a plan to gather incidence data over the receding twelve months.
Barrier 2: Needed additional funding to support a year study to determine the incidence in our community at this point in time.	**How overcome?** Sought local financial support from benevolent contribution plus the local Kiwanis Club.

Barrier 3: Lack of accurate knowledge on the part of key influential allies and advocates.	**How overcome?** Continuous process of educating, informing, listening, always checking out individuals assumptions - re: their understanding of the facts re: lead poisoning.

5. **How do you know this maternal and child health initiative has been *successful*?**

   The legislation passed, financial assistance has become available, more children are getting screening and treatment as needed.

6. **Do you think that this *initiative* would work if implemented in *another urban community*?** Yes **Why?** Develop a strong, diverse coalition, have as much supporting data as possible. Be persistent and patient.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	Multnomah County Health Div	City/State:	Portland, OR
Contact Person:	Mary L Hennrich RN MS	Telephone:	(503) 248-3674

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Access to early, comprehensive, client oriented prenatal care. "Innovative prenatal care Project."

2. **Describe the *major accomplishments* of this initiative.**

   - Reduced length of time low income women waited for initial prenatal appointment from 4-6 weeks to two weeks.
   - Reduced protocol of "standard" prenatal visits for medically low risk women to 5 visits with Nurse Practitioner/MD with client access to "Prenatal Drop-in Center" staffed by experienced Community Health Nurse every week-day afternoon. This reduction in visits previously "routinely" scheduled for all clients with NP/MD's allowed more women to be seen in clinic with same number of NP/MDs and only addition of staff was a half-time CHN.
   - Increased client and staff satisfaction as measured by independent researcher from Oregon Health Sciences University. Clients felt "required" visits more important and failed less often and liked "to be able to call or drop-in with other questions/concerns at their initiation/convenience." Staff, especially CHN's liked "being able to use their professional expertise and case management skills."
   - Pregnancy outcomes as measured by birth weight remained similar (avg. 3474 gms) with "reduced required" visits.
   - Educational/counseling/support services were more integrated with WIC and home visit services through nurse Drop-in Center who also taught combined classes and led small group discussions.

3. **How is it funded?** City/County/Local government funds; MCH block grant funds; 330 funds; Third party reimbursement (Medicaid, insurance) *(596 clients served in F.Y. '91-92 for a total clinic cost of $167,500 which incl. 0.5 new CHN.

   What is the approximate total annual budget for this initiative? $21,000.00* in addition to $146,500.00 PN Clinic.

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**	
Barrier 1: Staff resistance to change in "standard practice" and "roles."	**How overcome?** 1) Administrative commitment to "unbiased" evaluation; contracted with Health Sciences University to evaluate implementation and client outcomes. 2) Involved staff at clinic site in design and implementation of change. 3) Contracted with University OB/GYN Department and School of Nursing for staff training.
Barrier 2: Client underutilization of Drop-in Center at beginning of project.	**How overcome?** 1) Drop-in Center furnishings adapted to make it "non-clinical" and welcoming; healthful snacks usually available; lending library of materials available. 2) "Open Houses" for the DIC held with prizes and incentives offered to clients/community. 3) User-friendly fliers and posters informing prenatal and WIC clients about DIC and services.
Barrier 3:	**How overcome?**

5. How do you know this maternal and child health initiative has been *successful*?

Initial year-one evaluation report completed by OHSU researcher showed high degree of client and staff satisfaction. Increased number of clients were seen by same number of staff in F.Y. '91-92 (596 clients) as compared with F.Y. '90-91 (530 clients), only increase in cost was 0.5 CHN to staff Drop-in Center. Birth weights for clients with "reduced visit protocol" compared favorably with previous "control" group". Total clinic LBW for F.Y. '91-92 equals 3.6%.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** We plan to expand the way of delivering services to our other 4 prenatal clinic sites in next year. May need some modification to meet needs of clinics which have higher percentage of Hispanic and African-American clients. We plan to use focus groups of pregnant clients to customize services/delivery model to meet their perceived needs relative to Drop-in Center.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	Richmond City Health Department	City/State:	Richmond, VA
Contact Person:	Barbara Fleming CHIP Coordinator	Telephone:	(804) 233-2850
	Susan Lynch Nursing Director		(804) 780-4765

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   CHIP is a public/private partnership addressing fragmented, inadequate child health care by connecting low income families with children to community physicians for a medical home. PHN's provide care coordination and, with an outreach worker, guidance re: parenting, health, & resources.

2. **Describe the *major accomplishments* of this initiative.**

   This is a new project to Richmond. The past year has been spent building community support and planning the enrollment of the first clients, beginning September, 1992.

   a. Developed plan to integrate CHIP services with current health department services and planned primary care initiatives.
   b. Developed an Advisory Board with community and private business and medical participation.
   c. Developed a strong working relationship with Richmond Community Action Program (R-CAP) to support social outreach efforts.
   d. Hired a program coordinator, masters prepared, and support staff.
   e. Recruited first physicians into program.
   f. Obtained initial funding to reimburse physicians for non-Medicaid covered siblings of Medicaid covered clients.
   g. Obtained space in same facility with many community physicians to facilitate networking and partnership building.

3. **How is it funded?** City/County/Local government funds; General state funds; Kellogg Foundation;

   What is the approximate total annual budget for this initiative? $160,000.00

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**	
Barrier 1: Physician enrollment: The pilot area has a high ratio of low income families but only 2 pediatricians. Both have saturated practices and while supporting CHIP, they can accommodate only a few new clients.	**How overcome?** We are approaching other primary care MD's who usually service privately insured families and emphasize our desire to develop partnerships between them & PHD by asking how we can support their practice (e.g., hiring a PNP to expand the practice). Also emphasize care coordination and outreach effort that can minimize need for repeat visits, improve compliance and prevent some health problems.
Barrier 2: Limited funds for medical care reimbursement: Kellogg and state dollars could not be used to pay for medical care.	**How overcome?** We obtained initial funds from city to pay for medical care, prescriptions and lab work; primarily for non-Medicaid eligible siblings of Medicaid covered children. We are requesting more funding from other sources to expand the population we can enroll.
Barrier 3: Limited PHN resources to provide care coordination between physicians, dentists, and other health & social service agencies.	**How overcome?** Hire outreach workers to work under PHN direction to support PHN education, guidance, and follow-up efforts regarding health promotion, parenting and use of community resources. Eventually, two outreach workers will be assigned to each PHN.

5. How do you know this maternal and child health initiative has been *successful*?

Too early to determine since first clients won't be enrolled until September, 1992. However, we are highly optimistic because of the enthusiastic interest and support we have received from the community, including the City Council. Also, CHIP has been very successful in Roanoke, VA., where it originated 7 years ago.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** It is working well in Roanoke City, VA., and it is now being replicated in Richmond and three other cities in Virginia. One of its greatest strengths is the commitment to developing partnerships between the public health department and private medical community. These partnerships eliminate the threat of competition and promote the best use of the strengths of both; direct medical care from primary care providers and care coordination from public health nurses.

1992 Urban Maternal and Child Health Leadership Conference

Health Department: Monroe County Dept of Health City/State: Rochester, NY
Contact Person: Karin Duncan RN MS Telephone: (716) 274-6192

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Primary care for high risk population (foster care children).

2. **Describe the *major accomplishments* of this initiative.**

   In January, 1990, the Monroe County Department of Health and Department of Social Services combined efforts to implement a Pediatric Primary Care Clinic for children in Foster Care. The goal for this service was to provide quality care with continuity to a specific high risk population of children due, in part, to the instability in their family structure and support.

   The clinic provides comprehensive primary and preventive care to approximately 75 percent of Foster Care children in Monroe County. The provider model is a nurse practitioner/physician. Services for children are further coordinated by the provider through team meetings with DDS caseworker supervisors and PHN MCH staff. Children in Foster Care present a unique set of need to health care providers. This model clinic provides continuity for Foster Care families and children, as well as support for agency caseworkers responsible for the welfare of this population. Funding is through MCH net county dollars, medicaid reimbursement.

   The clinic is located in the DOH/DSS facility. Full time staff are 1 NP, 1 clerk; part-time staff are 2 physicians, 1 NP. Administrative responsibilities are with the DOH Clinic Coordinator.

3. **How is it funded?** City/County/Local government funds; General state funds; Third party reimbursement (Medicaid, insurance)

   What is the approximate total annual budget for this initiative? $200,000.00

4. What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?

Barrier 1: Establishing a credible, working relationship between two major departments both at an administrative and operational level.	**How overcome?** 1) Creating an environment for discussing the concept that allowed participants to express their anxieties and frustration; 2) Careful selection of staff that would be part of the project; 3) Thoughtful planning before implementation; 4) Clearly identifying benefits: To the children, DSS, DOH staff and practitioners in the community.
Barrier 2: Development of a primary care site that would be acceptable within the provider community. (Most of the foster care children were being cared for by community physicians.)	**How overcome?** Physician providers in the community needed to be convinced of the unique health, social needs of this population. This was accomplished by collegial discussions; demonstration of benefits of such a model; directives of DSS since these children were their responsibility. DOH provided minimal well-care to foster care children for many years. This model was clearly more efficient and beneficial.
Barrier 3: Financial support (The DOH clinic was not billing for any services at the time this clinic was established.)	**How overcome?** Systems were developed to access medicaid reimbursement at a clinic rate for these services. While this is not an official "managed care" program, the care provided is more closely monitored, coordinated by the single provider model.

5. How do you know this maternal and child health initiative has been *successful*?

Approximately 75% of all foster care children receive care in the clinic. There is a 15% no show rate. An active foster parents group has been formed. Their most recent project was refurbishing the clinic waiting area. Clinic staff have collaborated with the University of Rochester to establish a support group for children: KATS (Kids Adjusting Through Support). A high level of immunization compliance and decreased emergency room visits (no data yet available) are expected outcomes of this initiative.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** It does not require new money - This clinic is supported through third party reimbursement (medicaid) which the DSS was already paying to community providers, and net county dollars, which in turn, generate a percentage of state aid. The cost to operate this clinic is minimal. The keys to success of this clinic are collaboration, planning, careful selection of staff.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	Salt Lake City-County Health Department	City/State:	Salt Lake City, UT
Contact Person:	Jillian Jacobellis CNM MS	Telephone:	(801) 468-2724

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Access to child health care -- childhood morbidity and mortality.

2. **Describe the *major accomplishments* of this initiative.**

   PEDIATRICIANS "ADOPT-A-SCHOOL" PILOT PROJECT: The School Health- Private Sector partnership is a comprehensive health screening and treatment program which targets high risk elementary school children and their families. Although complete implementation has been delayed, the process of planning, marketing, and interagency coordination is profile-worthy. Pediatric access to care is a challenging issue in the county; the responsibility for providing this care continues to shift towards the local health department. It has been our experience that there is a tremendous amount of good will in the private provider community; with clearly defined service expectations, and community recognition for their service, providers are willing to volunteer their expertise to innovative public health programs.

   OBJECTIVE: Mobilize the private community proactive groups to provide voluntary services to at-risk children and their families in the school setting.

   METHODS: A Salt Lake County public health nurse provides on-site and home health screening, follow-up, and education to a target population of high risk children and their families. The private provider group who has adopted the school will provide gratis examination and treatment to those children the nurse has assessed as needing additional screening or incidental acute care and have no resource to pay for health care. A health department and medication and fluoride grant will be used to finance medications these children may need. The private provider group has also agreed to provide on-site educational classes.

3. **How is it funded?** City/County/Local government funds; Salt Lake City School Dist., Private Pediatric Group, Univ. of Utah, Dept. of Pediatrics.

   What is the approximate total annual budget for this initiative? Estimate: $18,500.00 (In-kind support not quantified at this juncture.)

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**	
Barrier 1: Complexities and preconceptions of the various agencies have made communication difficult.	**How overcome?** The partnership agencies have many common objectives and goals. Planning meetings to address these issues. Clearly defined channels of communication and agency expectations.
Barrier 2: The Providers are just one cog in the health delivery system. Other resources (diagnostic procedures, surgery, medications, mental and dental health), are often as difficult to obtain.	**How overcome?** This is a three-star barrier. Access other grant monies to provide medications and other sliding fee scale services. The public health nurse provides case-management for this population and addresses the issue of resources case-by-case.
Barrier 3:	**How overcome?**

5. How do you know this maternal and child health initiative has been *successful*?

The private provider community has been willing to contribute their resources and have demonstrated a shared ownership of the problem concerning issues of access to pediatric health care.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** Clearly, mobilizing the private provider community will work in any urban community; the blueprint is quite transferable. The important aspect is knowing the resisting and motivational forces of the provider culture and clearly defining the boundaries for the private sector.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	San Antonio Metropolitan Health District	City/State:	San Antonio, TX
Contact Person:	Lyn Burgess	Telephone:	(512) 225-1392

1. What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)

Cervical Dysplasia.

2. Describe the *major accomplishments* of this initiative.

1) Access to coloscopy /biopsy service for rural patients.

2) Decreased waiting period for services.

3) Matches urban resources with rural needs.

3. How is it funded? General state funds; Third party reimbursement (Medicaid, insurance)

What is the approximate total annual budget for this initiative? $119,000.00

4. What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?

Barrier 1: Personnel.	**How overcome?** 1) Hired nurse, aide and clerk. 2) Private clinicians contracted with to provide services.
Barrier 2: Equipment.	**How overcome?** Purchased equipment and used City clinics as base facility.
Barrier 3: Funding.	**How overcome?** Obtained grant funding from State resources.

5. How do you know this maternal and child health initiative has been *successful*?

Cases are reviewed with biopsy findings being confirmed in local cytology laboratory.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?**

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	San Juan Health Department	City/State:	San Juan, PR
Contact Person:	Mirla Maldonado Coordinator	Telephone:	(809) 751-6975

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Adolescent pregnancy, child abuse and prevention of substance abuse.

2. **Describe the *major accomplishments* of this initiative.**

   This initiative addresses the problem of poor child rearing skills of some parents. These are related to the lack of knowledge of psychosocial and physical development milestones, as well as, initiative strategies used. We consider this result in social problems as violence, drug use, adolescent pregnancy and runaways since child didn't develop effective strategies to deal with frustration and anger as well as positive self-esteem and values. These workshops consist of 3 hours a week, sessions of 8 week duration. These are offered in schools and/or community facilities on non-working hours (evenings). Some workshops are organized also to groups of parents that do not work at their convenience. Groups of 20-25 persons each. The following are some of the areas covered:

   1. Growth and development
   2. Child rearing strategies
   3. Self-esteem
   4. Adolescent sexuality
   5. Sexually transmitted disease and AIDS
   6. Use and abuse of drugs, alcohol and tobacco

   Behavioral red flag in experimentation with drugs, alcohol and tobacco as well as indicator of early sexual activities and effective ways to deal with it are presented.

3. **How is it funded?** City/County/Local government funds; Other: Volunteer resources for workshop community resources.

   What is the approximate total annual budget for this initiative? No budget assigned for this project.

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**	
Barrier 1: Poor cooperation from school personnel to promote parent qualification workshop.	**How overcome?** A series of meetings were done with school personnel to make clear the benefits from this workshop to parents and to the school itself.
Barrier 2: Recruitment of professional personnel to offer conference in parent qualification workshop.	**How overcome?** Difficult to overcome. It depends on commitment of these resources to offer time within their busy schedule to share experiences with parents without money benefits. We always have the volunteer help and commitment of 3 Psychologists, Pediatricians, School Nurse, School Health Coordinator from MCH staff and 1 MD from a Drug Prevention Program. Also AIDS Institute cooperate with resources when necessary.
Barrier 3: Workshop hours conflicted with working parents availability.	**How overcome?** Prior to start of workshop, needs assessment meetings are done to seek appropriate time schedule for working parents.

5. How do you know this maternal and child health initiative has been *successful*?

Post test administered. Parents are required to evaluate each section using an instrument created for such purpose. Feedback from school directors and social workers refer:

1) that child-parent relationship show improvement after participation in workshop;
2) parents participation in child academic performance have shown improvement;
3) parent-teacher communication has improved;
4) parents serve as community and school resources to other parents.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** Because this initiative deals with child-adolescent rearing problems that are common to all families.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	Seattle-King County Department of Public Health	City/State:	Seattle, WA
Contact Person:	Kathy Carson	Telephone:	(206) 296-4677

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Medicaid Application Workers in Health Department Sites: Access to Health Care.

2. **Describe the *major accomplishments* of this initiative.**

   This initiative uses local funds to draw down Federal Medicaid match for the delegated function of out reach and application assistance. The Health Department was able to convince city and county government that the use of local funds would be more than offset by additional Medicaid revenue for clinical services, which has been the case.

   Application workers, initially in half of the district offices but recently expanded to all eight of them, identify families coming for clinical services or the WIC program whose income status on the registration form appears to make them Medicaid eligible. If they have not indicated that they are on medical assistance on the registration form, the application worker seeks them out, explains the importance of having medical insurance, and offers to help them with the application. Using a packet of information the Health Department has put together to accompany the application, the worker assists the family in completing the forms and getting together the necessary verifications. This often requires a return visit since the family rarely has the verifications with them. When the application is completed, the Health Department worker sends it to the appropriate Medicaid office. If the family is applying for medical assistance only, they do not need to go to the Medicaid office; the Medicaid card will be returned in the mail.

3. **How is it funded?** City/County/Local government funds; Other: Medicaid Administrative Match

   What is the approximate total annual budget for this initiative? $212,662.00

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**

Barrier 1: Attitude of Health Department staff that many of their families would not want to accept "welfare."	**How overcome?** Education of entire staff, including providers, about the problems of access to health care, that Medicaid is currently the closest thing to national health insurance, and that the Health Dept is not able to meet all of the patient's health care needs.
Barrier 2: Resistance from local Medicaid agency.	**How overcome?** Initially, we called our staff eligibility workers (DSHS workers). DSHS was afraid they would not get credit for processing the applications; which would negatively impact their staff allocation. Once we understood their concerns, the name was changed to application workers, clarifying that they were still determining eligibility, reducing their anxiety. Application workers also met personally with DSHS eligibility workers to develop communication mechanisms, which greatly helped the system run more smoothly. The application workers meet monthly with a liaison from the Medicaid agency to problem solve and increase their expertise.
Barrier 3: Logistic constraints in each office.	**How overcome?** There are on-going problems with adequate space to interview families in private, access to computerized registration files, mechanisms to ensure that families get back to see the application worker after the clinic or WIC visit. These continue to be worked on.

5. How do you know this maternal and child health initiative has been *successful*?

Since the start, the Health Dept has been able to increase the number of families under the poverty level who are on Medicaid from 46% of our patient population to 62%. Medicaid revenues in the department have increased by 39%. Application workers have helped the Health Dept and the families it serves to take advantage of expanded eligibility and increased reimbursement levels, resulting in modest expansion of capacity even as local and state funding sources are being cut.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** In areas where Medicaid eligibility has been expanded, it is particularly advantageous to the Health Dept and to the families it serves. If the State still requires verification of the value of all assets or has not reduced the length of the application, it would be more difficult to implement. In states with more advantageous ration of federal match to state/local funds, it would require even less increase in Medicaid revenue to justify the expenditure of local funds.

1992 Urban Maternal and Child Health Leadership Conference

Health Department: St Paul Public Health Dept
Contact Person: Paula Henry/Anne Kuettel
City/State: St. Paul, MN
Telephone: (612) 292-7704 or 292-7731

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   The initiative primarily addresses immunizations and secondarily ensures that all children have a primary health care provider. This initiative targets the Women, Infant and Children clients (WIC).

2. **Describe the *major accomplishments* of this initiative.**

   This initiative, the Well Child Program, began in May of 1990 in response to the measles epidemic in St. Paul. During that period, it was identified that 54% of the measles cases in children age birth -5 years were WIC clients. This indicated that this population was not sufficiently imrnunized. As a result, from January, 1990 through June, 1992:

   - Well Child Programs have been established at all (5) WIC sites in St. Paul.
   - 308 clinics have been held
   - 6,732 immunization records were assessed
   - 8,816 clients received education
   - 5,216 immunizations have been given
   - 394 referrals were made

   Immunization records are entered on a computerized tracking system and are followed-up on to ensure compliance and up-to-date immunization status.

3. **How is it funded?** Third party reimbursement (Medicaid, insurance; Other: CHS Funding

   What is the approximate total annual budget for this initiative? $76,593.00

4. What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?

Barrier 1: Financial/Personnel resources needed exceeded those available at the beginning of the project.	**How overcome?** 1) This has not been totally overcome. Additional staff are still needed. 2) We have, however, been able to use some student interns periodically to help enter our backlog. 3) We continue to look for new sources of revenue and other opportunities to make budget shifts to support the program.
Barrier 2: Language/Cultural barriers and differences.	**How overcome?** 1) Materials are developed in appropriate languages. 2) We use health education assistants who speak the language of the group to whom services have been directed.
Barrier 3: Integrating the program with existing community providers.	**How overcome?** 1) This has been essential in continuing this program. 2) We have developed a public/private partnership in three of the clinics. The fourth clinic is run by St. Paul Public Health and the fifth clinic is run by a private neighborhood clinic.

5. How do you know this maternal and child health initiative has been *successful*?

We are still in the process of evaluating the success of this project. We can say that we have seen a tremendous increase in the number of immunizations given in our clinics. We are also seeing an increase in the number of children following a delayed schedule (from 6.7% in the first 6 months of 1991 to 10.6% in the first 6 months of 1992). This would indicate that we are getting some previously overdue children on their way to completing their series.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** The WIC program is a well established program where large groups of people in need come together. However, providing additional services can be very challenging due to language and cultural differences and low literacy levels. Sufficient research and planning must be done as well as resources made available in order for this initiative to work.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	Commission of Public Health Department of Human Services	City/State:	Washington, DC
Contact Person:	Patricia A Tompkins Chief, Office of MCH	Telephone:	(202) 673-4551

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Infant Mortality/Access to Health and Social Services.

2. **Describe the *major accomplishments* of this initiative.**

   The "At Your Fingertips: MOM's Resource Book" is an easy to read listing of local services of interest to pregnant women, mothers and their families. This manual is small in size and designed to be used by clients "in crisis."

   Over 12 major categories of services with a description of each service and how to access them are included in this document. To date almost 20,000 copies have been distributed to clients by health care and other providers such as teachers, probation officers and addiction counselors.

3. **How is it funded?** City/County/Local government funds: MCH block grant funds:

   What is the approximate total annual budget for this initiative? $35,000.00 (Approximately $1.75 per copy)

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**

Barrier 1: Complex and lengthy procurement procedures have made it difficult to maintain an adequate supply for distribution to providers, and thusly clients.	**How overcome?** An ongoing problem which we hope to alleviate through a contract. See Barrier #3 "How Overcome"
Barrier 2: Translating the book into the Spanish language for the D.C. Latino community.	**How overcome?** Collaborated with the Mayor's Office of Latino Affairs as well as bilingual colleagues within the Commission of Public Health.

Barrier 3: Updating the information in the book.	**How overcome?** Will be requesting additional funding to contract the entire process out to a private vendor.

5. How do you know this maternal and child health initiative has been *successful*?

MCH Hotline Staff using the Haines Criss Cross Directory sampled homes in the most disadvantaged areas of the District of Columbia and determined that most families had used the resource book and practically all of them were knowledgeable of the book.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** This initiative would be successful in other urban communities because it addresses a problem that consumers almost always articulate: "I don't know where to turn for services." The D.C. MOM's Resource Book is easy to read, small in size and sturdy.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	Division of Public Health Northeast State Service Center	City/State:	Wilmington, DE
Contact Person:	Anita Muir	Telephone:	(302) 577-3536

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Access to Health Care-One Stop Shopping; Northeast State Service Center Women and Child Health Clinic.

2. **Describe the *major accomplishments* of this initiative.**

   Full range of Public Health services located together with a wide range of Social Services:

   - Location is familiar and convenient to clients.
   - Several services can be accessed at one visit.
   - Agency staff make more referrals because they know each other.
   - Easier for clients to follow thru on referrals in same location.
   - Minimal number of entry points; each one for Public Health and Social Services.

   Public Health and Social Services share a mainframe computer system with multiple applications, in which all clients are registered in a single "Master Client Index."

   - Client registered to Medicaid is automatically "income eligible" for WIC. No income verification needed.
   - Clients with a delinquent immunization status are "flagged" in the WIC system; Child health nurse can immunize on the spot or arrange an appointment, as needed.
   - "Missing" clients can be "flagged" on the system, so that if they are seen by one agency, the other agency may be notified of their whereabouts.
   - Likewise, a client who moves from place to place, may be located by one agency and address is changed in the system.

3. **How is it funded?** City/County/Local government funds: MCH block grant funds: Other Federal funds

What is the approximate total annual budget for this initiative?

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**

Barrier 1: Collocation is not enough. Agency staff must learn to work together. Major program differences and requirements exist.	**How overcome?** Long, slow process. Staff must become familiar with other programs/agencies. Support and leadership from administration to remove barriers is crucial.
Barrier 2: Computer systems for various agencies are at different levels of sophistication and development. Registration information is common to all agencies, but system links are needed to promote improved services to clients, while protecting confidentiality.	**How overcome?** Agencies need to meet to identify common data needs, and ways to benefit the client (i.e. WIC/Medicaid income eligibility).
Barrier 3: As agencies and services grow, space needs increase and there is a tendency to find space for service elsewhere, thus splitting the one stop shopping concept.	**How overcome?** Planning for space and growth must be addressed by multi-agency groups, who must make a commitment to the one stop concept.

5. **How do you know this maternal and child health initiative has been *successful*?**

Positive feedback from clients served through this system by multiple agencies. High percentage of clients are registered for multiple services. Delinquent immunization rate has decreased in this area.

6. **Do you think that this *initiative* would work if implemented in *another urban community*?** Yes **Why?** This approach requires a strong top-down commitment from the administration of various agencies. In Delaware, the Department of Health and Social Services includes the Division of Public Health, Division of Social Services, and the Division of State Social Service Centers which is the location of the one stop shopping services. Community Centers can utilize this model by housing the agencies which their community is most in need of and by working to unite the agencies with a common goal of coordinated services to the client.

1992 Urban Maternal and Child Health Leadership Conference

Health Department:	Westchester County Department of Health	City/State:	Yonkers, NY
Contact Person:	Harold N Adel MD MPH Deputy Commissioner Community Health Services	Telephone:	(914) 593-5070

1. **What *maternal and child health problem(s)* does this initiative address? (e.g. low birth weight and infant mortality, poverty, substance abuse, adolescent pregnancy, access to health care, violence, etc.)**

   Adolescent pregnancy, low birth weight, infant mortality, access to health care, parenting skills, self-sufficiency, domestic violence, sexual, physical and emotional abuse.

2. **Describe the *major accomplishments* of this initiative.**

   Overall Program Accomplishments:

   Ongoing case management is provided for pregnant and parenting adolescents, and adolescents at risk for pregnancy. Direct referral systems are in place with multitude of social service, financial assistance, job placement/career development, child care, health care, psychotherapy and related organizations. The program has been successful in recruiting and retaining adolescents with a wide range of psychosocial difficulties, particularly those from severely dysfunctional family environments. Bi-weekly "Family Time" Support groups have been an effective vehicle for participants growth towards self-sufficiency and personal development. Since 1987, 12 Peer Counselors have been recruited to further the programs' efforts.

   Peer Counseling Program:

   Currently, 4 Peer Counselors provide service to the program; all were recruited while program participants based on expressed interest and demonstrated skills. Peer counselors participate in Family Time Support Groups, provide individual counseling, conduct outreach presentations in area schools and community agencies serving adolescents. Professional education programs have been conducted for medical providers at a local hospital and at an area teachers' college and board of education.

3. **How is it funded?** City/County/Local government funds: MCH block grant funds through NYSDOH

   What is the approximate total annual budget for this initiative? $111,250.00

4. **What have been the *greatest barriers* faced in implementing this initiative? How did you *overcome* them?**	
Barrier 1: Lack of funding for peer counselor component.	**How overcome?** Continuous recruitment of peer counselor volunteers. Outstanding commitment on the part of counselors to the Teen Linkage Program's mission. Reinforcement of peer counselor efforts and recognition of their contribution to the program.
Barrier 2: Difficulty in acceptance of peer counselor services by target population.	**How overcome?** Gradual introduction to peer counselors through a variety of program activities. Ongoing peer counselor training by program staff in areas of establishment of rapport, realistic expectations in peer counselor role.
Barrier 3:	**How overcome?**

5. How do you know this maternal and child health initiative has been *successful*?

Since 1/89, there have been 66 live births to Teen Linkage Clients, and 0% low birth weight. In contrast from 1/85-1/88 the LBW rate was 6.5%. In past year, no clients have had repeat pregnancies at 12 and 24 month follow-up. Peer counselors presently providing services have stayed with the program for approximately two years; in the past, counselors have continued with the program over 2 years. Anecdotal information from clients demonstrates marked improvements in abilities to cope with suicidal tendencies and other severe psychosocial problems based on their successful relationship with the peer counselors.

6. Do you think that this *initiative* would work if implemented in *another urban community*? Yes **Why?** Provided staff accepts the inherent benefit of peer counselors and that sufficient time and effort is devoted to foster commitment and training for peer counselor volunteers.

Section III

APPENDICES

APPENDIX A: 1993 Conference Planning Committee

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APPENDIX B: Conference Program

"Strengthening Urban MCH Capacity"

Sunday, September 13, 1992

9:00am - 12:00pm	**CityMatCH Board of Directors Meeting** for outgoing and newly elected members	**Smithsonian**
1:30pm - 2:30pm	**1992 Conference: Work Group Leaders Training Session**	**Omni Club**
2:30pm - 5:30pm	**Municipal MCH Partners Project Advisory Committee** quarterly cooperative agreement meeting	**Smithsonian**
4:30pm - 7:30pm	**Conference Registration**	**Phillips Foyer**
5:00pm - 5:30pm	**Orientation for New CityMatCH Members**	**Freer Suite**
5:30pm - 7:30pm	**Welcoming Reception**	**Phillips Ballroom**

Monday, September 14, 1992

7:00am - 8:00am	**Registration & Continental Breakfast**	**Phillips Ballroom**
8:00am - 8:15am	**Welcoming Remarks**	**Phillips Ballroom**
	Betty Thompson, RN, CFNC Director, MCH Programs Nashville Metropolitan Health Department Co-Chair, 1992 Urban MCH Leadership Conference	
	Mohammad Akhter, MD Commissioner of Public Health District of Columbia Commission on Public Health	
8:15am - 8:30am	**1992 Conference Overview**	**Phillips Ballroom**
	Magda G. Peck, ScD, PA Executive Director, CityMatCH Co-Chair, 1992 Urban MCH Leadership Conference	
8:30am - 9:30am	**Federal Perspectives on Urban MCH**	**Phillips Ballroom**
	Audrey Hart Nora, MD, MPH Assistant Surgeon General Acting Director Maternal and Child Health Bureau Health Resources and Services Administration	
	Robert Harmon, MD, MPH Administrator Maternal and Child Health Bureau Health Resources and Services Administration	
	Antonia Coella Novello, MD United States Surgeon General U.S. Public Health Service	
9:30am - 10:15am	**MCH in the Cities: A Local Perspective**	**Phillips Ballroom**
	Paul Nannis, MSW President, U.S. Conference of Local Health Officers Commissioner of Health Milwaukee Health Department	
	The Honorable Michael White (invited) Mayor of Cleveland Chair, Health Committee U.S. Conference of Mayors	
10:15am - 10:45am	Break	**Phillips Ballroom**

10:45am - 12:00pm	**Shaping Local MCH Policy: the Case of Richmond, VA** **Lisa L. Friend, MD, MPH** Deputy Health Director Richmond City Health Department **C.M.G. Buttery, MD, MPH** Health Director Richmond City Health Department **Peter Walker, PhD** Administrator, Office of Minority Health Richmond City Health Department **Joyce Smith Wilson, MPA** Chief of Staff Richmond City Manager's Office	**Phillips Ballroom**
12:00pm - 1:30pm	**Cities Networking Luncheon** (participants will sit by city size)	**National Ballroom**
1:45pm - 3:00pm	**Local Health Partnerships: Collaboration and Cooperation in Kansas City, MO** **Sidney L. Bates, MA** Chief of Maternal and Child Health Services Kansas City (MO) Health Department **James Nunnelly, MPH** Administrator Samuel U. Rodgers Community Health Center Kansas City, MO **Latrica McArn, MA** President, ABBA Industries Private Consultant Kansas City, MO	
3:00pm - 3:30pm	Break	**Phillips Ballroom**
3:30pm - 5:00pm	**Problem Solving Work Groups** small group discussions on strategies for effective collaboration and policymaking at the local level	

Tuesday, September 15, 1992

7:30am - 8:00am	**Continental Breakfast**	**Phillips Ballroom**
8:00am - 8:10am	**Announcements and Introductions**	**Phillips Ballroom**
8:10am - 9:10am	**Healthy Start in 1992: an Update from the Field**	**Phillips Ballroom**

Thurma McCann, MD, MPH
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Diane Weems, MD
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9:15am - 10:15am	**Cultural Diversity in Urban MCH Programs**	**Phillips Ballroom**

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COSSMHO Fellow, National Coalition of Hispanic Health & Human Services Organizations

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Mareasa R. Isaacs, PhD
President of the Isaacs Group
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10:15am - 10:30am	Break	**Phillips Ballroom**

10:30am - 12:00pm	**Problem Solving Work Groups** small group discussions on addressing cultural diversity in urban MCH programs	
12:15pm - 2:00pm	**Co-Sponsors Host Luncheon and Ask-a-Colleague Session**	**National Ballroom**
3:00pm - 7:00pm	**Exhibitor's Showcase: New Urban MCH Initiatives**	**Renwick**
5:00pm - 7:00pm	**Urban MCH Networking Session**	**National Ballroom**
5:30pm - 6:30pm	**1992 CityMatCH "SpotLights"** recognizing innovations in urban MCH programs	**National Ballroom**

Wednesday, September 16, 1992

7:30am - 8:00am	**Continental Breakfast**	**Phillips Ballroom**
8:00am - 10:00am	**CityMatCH Annual Business Meeting**	**Phillips Ballroom**
10:00am - 10:30am	Break	**Phillips Ballroom**
10:30am - 11:00am	**What Works in Immunizations: Preliminary Findings from the 1992 CityMatCH Survey** **Phyllis Stubbs, MD, MPH** Chief, Early Childhood Health Branch Division of Maternal, Infant, Child and Adolescent Health Maternal and Child Health Bureau **Magda G. Peck, ScD, PA** Executive Director, CityMatCH	**Phillips Ballroom**
11:00am - 12:00pm	**Immunization Issues Facing Urban Health Departments** **Kay Johnson, MPH** Senior Health Policy Analyst March of Dimes Birth Defects Foundation **Walter A. Orenstein, MD** Director, Division of Immunizations National Center for Prevention Services Centers for Disease Control **Robert K. Ross, MD** Commissioner of Health Philadelphia Department of Public Health	**Phillips Ballroom**
12:00pm - 1:30pm	**Regional Urban MCH Luncheon** (participants will sit by federal region)	**National Ballroom**
1:30pm - 2:00pm	**Closing Remarks** **Edward Ehlinger, MD, MPH** Past Chairperson CityMatCH Board of Directors Director, Division of Personal Health Services Minneapolis Health Department	**National Ballroom**
2:00pm	**Final Adjournment**	
2:10pm - 5:00pm	**Field Visits to Area MCH Programs (optional)**	

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- ☐ F025 Forging an Urban MCH Partnership: 1991 Urban Maternal and Child Health Leadership Conference (out of print)
- ☐ G004 Strengthening Urban MCH Capacity: Highlights of the 1992 Urban Maternal and Child Health Leadership Conference
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